

EXHIBIT A

To: Bob Brockman[bob_brockman@reyrey.com]
From: Stuart Yudoisky[stuart.yudoisky@gmail.com]
Sent: Thur 5/4/2017 12:27:18 AM (UTC)
Subject: Anosmia

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Good evening, Bob:

There are dozens of potential causes of anosmia--as there are for memory loss.

If you are comfortable doing so, I suggest that you begin by meeting with me. That will help me assess the severity and significance of your memory symptoms, as well as utilize this information to direct you to the best professional-- discipline, person, and/or system--for assessment and, as required, care.

As you know, Bob, I am a neuropsychiatrist and have extensive hands-on experience with memory and cognitive changes.

I am available in the mornings from 9 AM until noon over the next several days, and can be available at any time over the weekend.

Please let me know how you would like to proceed.

Warmest regards,

Stuart

On May 3, 2017, at 4:27 PM, Bob Brockman <bob_brockman@reyrey.com> wrote:

Stuart,

Robert and Dorothy are after me to consult with the right doctor regarding my loss of my sense of smell.

They are afraid that it is an early sign of alzheimer's or dementia.

I am feeling good but am having increasing memory problems.

Is there a doctor that you can recommend?

Bob

EXHIBIT B

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Seth Paul Lerner, M.D.,
FACS

Professor
713-798-
4001

Request Clinical Appointment

Email

slerner@bcm.edu

Positions

Professor

Urology

Baylor College of Medicine

Houston, TX US

Beth and Dave Swalm Chair in Urologic Oncology Director of Urologic Oncology Director of the Multidisciplinary Bladder Cancer Program

Addresses

Baylor College of Medicine Medical Center (Clinic)

7200 Cambridge, Suite 10B

Houston, TX 77030

United States

(713) 798-4001

Education

B.A. from University Of Texas At Austin

01/1979 - Austin, TX United States

M.D. from Baylor College Of Medicine

01/1984 - Houston, TX United States

Internship at Virginia Mason Hospital

01/1985 - Seattle, Washington United States

Residency at Virginia Mason Hospital

06/1986 - Seattle, Washington United States

General Surgery

Residency at Baylor College of Medicine

06/1990 - Houston, Texas United States

Urology

Fellowship at University Of Southern California

06/1992 - Los Angeles, California United States

Urologic Oncology

Certifications

American Board of Urology

Professional Interests

- Urologic Oncology and Reconstructive Surgery with Interest in Minimally Invasive Surgery
-

Professional Statement

Seth P. Lerner, MD, is Professor of Urology and holds the Beth and Dave Swalm Chair in Urologic Oncology, in the Scott Department of Urology, Baylor College of Medicine. He is Director of Urologic Oncology and the Multidisciplinary Bladder Cancer Program and Faculty Group Practice Medical Director for the Urology Clinic.

He earned his medical degree from Baylor College of Medicine, completed a surgical internship at Virginia Mason Hospital in Seattle, and returned to Baylor for his residency training. He completed a two-year fellowship at the University of Southern California in urologic oncology and reconstructive surgery under Peter Jones and Don Skinner before returning to join the full-time Baylor faculty in 1992. His clinical practice, education, and research activities are devoted to urologic oncology and particularly lower and upper tract urothelial cancer.

Dr. Lerner is author of over 190 peer-reviewed articles, and co-editor of a comprehensive Textbook of Bladder Cancer. He is the founding co-editor-in-chief of the Bladder Cancer journal. He established and directs the multi-disciplinary Bladder Cancer Research Program at Baylor and his research interests include use of selective estrogen receptor modulators for treatment of bladder cancer, gene therapy, integrated genomic analysis of bladder and upper urinary tract cancers, and outcomes of radical cystectomy and pelvic lymphadenectomy. He has 26 years experience as a clinical investigator for both NCI and industry funded clinical trials. He is the PI of the ongoing SWOG NCI Phase III trial comparing extended vs. standard pelvic lymphadenectomy at time of radical cystectomy. He is active in the leadership of several national bladder cancer research enterprises including chair of the Local Bladder Cancer committee of SWOG, founding and former co-chair of the NCI Bladder Cancer Task Force and current co-chair of the NCI CTEP Genitourinary Steering Committee, and he has co-chaired the Analysis Working Group of The Cancer Genome Atlas Project

for muscle invasive bladder cancer for the past 7 years. He is very active in the Bladder Cancer Advocacy Network (BCAN) as a member of the Board of Directors, past chair of the Bladder Cancer Think Tank and co-chair of the management committee of the Bladder Cancer Research Network. Dr. Lerner is an active member of the prestigious American Association of Genitourinary Surgeons and is listed routinely among "America's Top Doctors" and "Best Doctors in America."

Websites

[Scott Department of Urology](#)

[Dr. Lerner's Research](#)

[VIICTR Research Database](#)

[BCM MyChart](#)

Selected Publications

- Levitt JM, Jian W, Lerner SP, Sonpavde G "A conventional preclinical schedule of cisplatin is more effective than a metronomic frequent bolus schedule for urothelial carcinoma.." *Urol. Oncol.*. 2013 February ; 31 (2): 234-40. Pubmed PMID: [21723160](#)
- Burke JM, Lamm DL, Meng MV, Nemunaitis JJ, Stephenson JJ, Arseneau JC, Aimi J, Lerner S, Yeung AW, Kazarian T, Maslyar DJ, McKiernan JM "A First in Human Phase 1 Study of CG0070, a GM-CSF Expressing Oncolytic Adenovirus, for the Treatment of Nonmuscle Invasive Bladder Cancer.." *J. Urol.*. 2012 December ; 188 (6): 2391-7. Pubmed PMID: [23088985](#)
- Meeks JJ, Bellmunt J, Bochner BH, Clarke NW, Daneshmand S, Galsky MD, Hahn NM, Lerner SP, Mason M, Powles T, Sternberg CN, Sonpavde G "A Systematic Review of Neoadjuvant and Adjuvant Chemotherapy for Muscle-invasive Bladder Cancer.." *Eur. Urol.*. 2012 September ; 62 (3): 523-33. Pubmed PMID: [22677572](#)
- Jian PY, Godoy G, Coburn M, Lynch G, Ro JY, Zhai QJ, Nishino M, Lerner SP "Adenocarcinoma following urinary diversion.." *Can Urol Assoc J.* 2012 April ; 6 (2): E77-80. Pubmed PMID: [22511440](#)

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Memberships

American Association of Genitourinary Surgeons

Member

American Urological Association

Member

American Association for Cancer Research

Member

American Association for the Advancement of Science

Member

American College of Surgeons

Fellow

American Medical Association

Member

American Society of Clinical Oncology

Member

American Society of Gene Therapy

Member

American Association of Clinical Urologists

Member

Harris County Medical Society

Member

International Bladder Cancer Network

Member

Society of Basic Urologic Research

Member

Société Internationale D'Urologie

Member

Society of Laparoendoscopic Surgeons

Member

South Central Section of the American Urological Association

Member

Society of University Urologists

Member

Southwest Oncology Group

Member

Texas Urological Society

Member

Texas Medical Association

Member

Skills

Research Interests

Bladder Cancer Collaborative Research Program: Role of estrogen receptors and the use of selective estrogen receptor modulators (e.g., tamoxifen) for treatment of bladder cancer; novel targeted therapeutics and gene therapy for treatment of non-muscle-invasive and invasive disease; outcome of treatments for non-muscle-invasive bladder cancer and radical cystectomy and development of predictive models; genomic characterization and integrated analysis of bladder and upper tract cancers

Clinical Interests

Urologic oncology and urinary tract reconstruction; management of patients with bladder, prostate, testis and kidney cancer; Director, Bladder Cancer Multidisciplinary Clinical Program

Clinical Trials

Bladder cancer; prostate cancer; kidney cancer

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Baylor College of Medicine > Find a Person > James Pool



James L Pool, M.D.

Professor

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Positions

Professor

Medicine-Hypertension
Baylor College of Medicine
Houston, TX US

James L. Pool Presidential Endowed Chair in Clinical Pharmacology

Baylor College of Medicine
Houston, Texas United States

Addresses

Baylor Comprehensive Healthcare Clinic (Clinic)

1977 Butler Blvd. E6.150
Houston, TX 77030
United States
(713) 798-0180

Education

MD from University Of Oklahoma School of Medicine

06/1972 - Oklahoma City, Oklahoma United States

Internship at Duke University Medical Center

01/1973 - Durham, North Carolina United States
Internal Medicine

Residency at Duke University Medical Center

01/1975 - Durham, North Carolina United States
Internal Medicine

Fellowship at Duke University Medical Center

01/1976 - Durham, North Carolina United States
Endocrinology

Certifications

Internal Medicine

American Board of Internal Medicine

Diplomate

American Board of Endocrinology and Metabolism

Diplomate

American Board of Clinical Pharmacology

Professional Interests

- Cardiovascular Pharmacology
 - Alteration of Lipid Metabolism by Antihypertensive Drugs
 - Autonomic Nervous System Dysfunction
-

Websites

[VIICTR Publications List](#)

[Cardiovascular Disease Prevention Care Center](#)

Selected Publications

- Taylor AA, Pool JL "[Clinical role of direct Renin inhibition in hypertension..](#)" *Am J Ther.* 2012 May ; 19 (3): 204-10. Pubmed PMID: [21317620](#)
- Perlstein TS, Henry RR, Mather KJ, Rickels MR, Abate NI, Grundy SM, Mai Y, Albu JB, Marks JB, Pool JL, Creager MA "[Effect of angiotensin receptor blockade on insulin sensitivity and endothelial function in abdominally obese hypertensive patients with impaired fasting glucose..](#)" *Clin. Sci.* 2012 February 1; 122 (4): 193-202. Pubmed PMID: [21861845](#)
- Hyman DJ, Pavlik VN, Greisinger AJ, Chan W, Bayona J, Mansyur C, Simms V, Pool J "[Effect of a physician uncertainty reduction intervention on blood pressure in uncontrolled hypertensives-a cluster randomized trial..](#)" *J Gen Intern Med.* 2012 April ; 27 (4): 413-9. Pubmed PMID: [22033742](#)
- Clement S, Brohan E, Sayce L, Pool J, Thornicroft G "[Disability hate crime and targeted violence and hostility: A mental health and discrimination perspective..](#)" *J Ment Health.* 2011 June ; 20 (3):

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Joseph Jankovic, M.D.

Professor

713-798-6556

Request Clinical Appointment

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Positions

Professor

Neurology

Baylor College of Medicine

Distinguished Chair in Movement Disorders

Baylor College of Medicine

Director

Parkinson's Disease Center and Movement Disorders Clinic

Baylor College of Medicine

Director, Centers of Excellence

National Parkinson Foundation

Huntington's Disease Society of America Tourette Syndrome Association

Program Director

Movement Disorders Fellowship

Baylor College of Medicine

Addresses

Parkinson's Disease Center and Movement Disorders Clinic (Clinic)

Baylor College of Medicine Medical Center

7200 Cambridge St., 9th Floor, MS: BCM609

Houston, TX 77030

United States

(713) 798-2273

[Neurology Site](#)

Education

MD from University of Arizona College of Medicine

06/1973 - Tucson, Arizona United States

Internship at Baylor College of Medicine

06/1974 - Houston, Texas United States

Internal Medicine

Residency at The Neurological Institute, Columbia University

06/1977 - New York, NY United States

Neurology

Certifications

American Board of Psychiatry and Neurology, Neurology

Honors & Awards

Past President

International Parkinson and Movement Disorder Society (01/1994 - 01/1996)

Honorary Member

American Neurological Association Australian Association of Neurologists European Federation of Neurological Societies French Neurological Society International Parkinson and Movement Disorder Society

Great Teacher Award

National Institutes of Health

Movement Disorders Research Award

Sponsored by the Parkinson's Disease Foundation

American Academy of Neurology

Distinguished Service Award

National Parkinson Foundation

Guthrie Family Humanitarian Award

Huntington's Disease Society of America

Lifetime Achievement Award

Tourette Syndrome Association

Distinguished Service Award

Dystonia Medical Research Foundation

Distinguished Faculty Award

Baylor College of Medicine Alumni Association

Fulbright and Jaworski Faculty Excellence Award

Baylor College of Medicine

Master Clinician Lifetime Award

Baylor College of Medicine

Past President

International Neurotoxin Association (01/2015 - 12/2017)

Professional Interests

- Neurology
- Movement Disorders
- Parkinson's Disease and related neurodegenerative disorders
- Tremors
- Dystonia
- Tics
- Tourette's syndrome
- Chorea
- Huntington's disease
- Restless leg syndrome
- Tardive dyskinesias
- Paroxysmal dyskinesias
- Ataxia

Professional Statement

Joseph Jankovic, M.D. is Professor of Neurology, Distinguished Chair in Movement Disorders, and Founder and Director of the Parkinson's Disease Center and Movement Disorders Clinic (PDCMDC), Department of Neurology, Baylor College of Medicine, Houston, Texas. After completing his Neurology training at Columbia University, New York City, he joined the faculty of Baylor College of

Medicine in 1977. Since that time he has led clinical and research team that focuses on etiology, pathophysiology, and experimental therapeutics of Parkinson's disease and related neurodegenerative and movement disorders such as tremors, dystonia, Tourette syndrome, Huntington disease, restless legs syndrome, tardive dyskinesia, and paroxysmal dyskinesias. Under the direction of Dr. Jankovic the PDCMDC has been recognized as "Center of Excellence" by the Parkinson's Foundation, the Huntington Disease Society of America, the Tourette Association of America, and the Wilson Disease Association.

Past president of the International Parkinson and Movement Disorder Society and of the International Neurotoxin Association, Dr. Jankovic is the recipient of many awards including the American Academy of Neurology Movement Disorders Research Award, First National Parkinson Foundation Distinguished Service Award, Huntington's Disease Society of America Guthrie Family Humanitarian Award, Tourette Syndrome Association Lifetime Achievement Award, Dystonia Medical Research Foundation Distinguished Service Award, Benign Essential Blepharospasm Research Foundation Award, and Lifetime Achievement Award from the International Neurotoxin Association, Dr. Jankovic has published over 1,200 original articles and over 55 books, is included among "Highly Cited Researchers", and has been ranked #1 expert in the world in movement disorders and in botulinum toxins (<http://expertscape.com/>).

He has served as the principal investigator in hundreds of clinical trials and his pioneering research on drugs for parkinsonian disorders and hyperkinetic movement disorders has led to their approval by the Food and Drug Administration. Dr. Jankovic is current or past member of many scientific and medical advisory boards and has served on the executive scientific advisory boards of the Michael J. Fox Foundation for Parkinson's Research and the National Parkinson Foundation. Dr. Jankovic has mentored numerous fellows and other trainees many of whom have become leaders in the field of neurology and movement disorders. For further information visit www.jankovic.org.

Websites

[Parkinson's Disease Center and Movement Disorders Clinic](#)

[In the News](#)

[Dr. Jankovic's Bibliography](#)

Comprehensive list of publications and presentations

[Dr. Jankovic's Research](#)

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Videos

Joseph Jankovic, M.D. - Giving Life to Possible

Joseph Jankovic, M.D. is board certified in psychiatry and neurology specializing in movement disorders and Parkinson's disease. His clinical interests include: movement disorders, Parkinson's disease and related neurodegenerative disorders.

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Melissa Michelle Yu, M.D.,
FAAN

Associate
Professor
713-798-
2273

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Positions

Associate Professor

Neurology

Baylor College of Medicine

Associate Medical Director

Baylor Clinic

Neurology

Baylor College of Medicine

Associate Director, Clinical Operations

Alzheimer's Disease and Memory Disorders Center

Baylor College of Medicine

Houston, Texas

Faculty Senator

Baylor College of Medicine

Houston, Texas United States

Physician Informaticist

Baylor College of Medicine

Addresses

Baylor Neurology - Alzheimer's Disease and Memory Disorders Center (Clinic)

7200 Cambridge St., 9th Floor

McNair Campus

Houston, TX 77030

United States

(713) 798-4734

<https://www.bcm.edu/healthcare/care-centers/neurology>

Education

MD from Mt. Sinai School of Medicine

05/2000 - New York City, New York United States

Internship at St. Luke's-Roosevelt Hospital Center

06/2001 - New York City, New York United States

Internal Medicine

Residency at Baylor College of Medicine

06/2004 - Houston, Texas United States

Neurology

Graduate Certificate at Jesse H. Jones Graduate School of Management of Rice University

03/2014 - Houston, Texas United States

Healthcare Management

Graduate Certificate at University of Texas, School of Biomedical Informatics

12/2016 - Houston, Texas United States

Healthcare Informatics

Certifications

Neurology

American Board of Psychiatry and Neurology

Clinical Informatics

American Board of Preventive Medicine

Professional Interests

- Memory disorders
- Healthcare Management
- Electronic Medical Records
- Process Improvement
- Quality Improvement
- Healthcare Informatics

Memberships

American Academy of Neurology

Languages

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Michele K York, Ph.D.,
ABPP-CN

Professor
713-798-
8673

[Request Clinical Appointment](#)

Email

myork@bcm.edu

Positions

Professor

Neurology and Psychiatry and Behavioral Sciences
Baylor College of Medicine

Head

Section of Neuropsychology
Baylor College of Medicine

Addresses

Baylor College of Medicine Medical Center (Clinic)

7200 Cambridge St., 9th Floor
Houston, TX 77030
United States
(713) 798-8673

Education

Internship at Baylor College Of Medicine

01/2000 - Houston, Texas United States
Clinical Psychology

PhD from Vanderbilt University

01/1998 - Nashville, Tennessee United States

MA from Vanderbilt University

01/1996 - Nashville, Tennessee United States

BA from Vanderbilt University

01/1993 - Nashville, Tennessee United States

Certifications

Clinical Neuropsychology

American Board of Professional Psychology

Honors & Awards

Fulbright and Jaworski LLP Faculty Excellence Award for Teaching and Evaluation

Baylor College of Medicine (01/2012)

Fulbright and Jaworski LLP Faculty Excellence Award for Enduring Materials

Baylor College of Medicine (09/2012)

Norton Rose Fulbright LLP Faculty Education Award for Teaching and Evaluation

Baylor College of Medicine (09/2018)

Norton Rose Fulbright LLP Faculty Education Award for Enduring Materials

Baylor College of Medicine (01/2019)

Star Award for Clinical Excellence

Baylor College of Medicine (01/2019)

Websites

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Selected Publications

- Hack N, Akbar U, Thompson-Avila A, Fayad SM, Hastings EM, Moro E, et al "[Impulsive and Compulsive Behaviors in Parkinson Study Group \(PSG\) Centers Performing Deep Brain Stimulation Surgery.](#)" *J Parkinsons Dis.* 2014 January 1; 4 (4): 591-8. Pubmed PMID: 25035311
- Rothlind JC, York MK, Carlson K, Luo P, Marks WJ, Jr, et al "[Neuropsychological changes following deep brain stimulation surgery for Parkinson's disease: comparisons of treatment at](#)

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pallidal and subthalamic targets versus best medical therapy." *J Neurol Neurosurg Psychiatry*.
2014 September 2; : Pubmed PMID: 25185211

- Fridley J, Adams G, Sun P, York M, Atassi F, Lai E, et al "Effect of subthalamic nucleus or globus pallidus interna stimulation on oculomotor function in patients with Parkinson's disease." *Stereotact Funct Neurosurg*. 2013 91 (2): 113-21. Pubmed PMID: 23343617
- Calleo J, Burrows C, Levin H, Marsh L, Lai E, York MK "Cognitive rehabilitation for executive dysfunction in Parkinson's disease: application and current directions.." *Parkinsons Dis*. 2012 2012 : 512892. Pubmed PMID: 22135762

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Memberships

Academy of Distinguished Educators

Member (01/2012)

American Academy of Neurology

Movement Disorders Society

International Neuropsychological Society

Parkinson Study Group

American Congress of Rehabilitation Medicine

Co-Chair Elect (09/2018)

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Attorneys for Defendant
ROBERT T. BROCKMAN

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

ROBERT T. BROCKMAN,

Defendant.

Case No. 3.20-cr-00371-WHA

DECLARATION OF JAMES L. POOL,
M.D., IN SUPPORT OF ROBERT T.
BROCKMAN'S MOTION TO
TRANSFER PROCEEDINGS

DECLARATION OF JAMES L. POOL, M.D.

I, James L. Pool, M.D., declare as follows:

1. I am a Professor in the Departments of Medicine and Pharmacology and a treating internal medicine physician at the Baylor College of Medicine, in Houston, Texas, where I hold the James L. Pool Presidential Endowed Chair in Clinical Pharmacology.

2. I make this Declaration at the request of his counsel in support of Mr. Brockman's Motion to Transfer Proceedings to the United States District Court for the Southern District of Texas.

1 3. Mr. Brockman was referred to me by Dr. Seth P. Lerner (Baylor College of
2 Medicine, Department of Urology), who had previously treated Mr. Brockman for bladder cancer.
3 I conducted a complete physical examination of Mr. Brockman on December 11, 2018. It
4 became evident from my examination that Mr. Brockman was experiencing movement disorders
5 and cognitive problems that are consistent with Parkinson's disease or parkinsonism.

6 4. I referred Mr. Brockman to three other medical professionals: Joseph Jankovic,
7 M.D., a neurologist and specialist in Parkinson's disease and other movement disorders; Melissa
8 Yu, M.D., a neurologist and specialist in Alzheimer's Disease and other memory disorders; and
9 Michele K. York, Ph.D., a neuropsychologist, all with Baylor College of Medicine.

10 5. Each of these doctors provided me with reports following their examinations.
11 Their conclusions support that Mr. Brockman presented symptoms that are consistent with
12 Parkinson's Disease, parkinsonism, Lewy body dementia, or some combination. These diagnoses
13 cannot be totally confirmed except at autopsy. None of these conditions are curable, and each
14 may result in rigid muscles, slow movements, and tremors. All are characterized by progressive
15 dementia, and in Mr. Brockman's case, the medical reports confirm cognitive impairment, which
16 includes, but is not limited to, both short and long term memory loss.

17 6. I examined Mr. Brockman again on October 6, 2020. At that time, I conducted
18 cognitive tests, and again referred Mr. Brockman to Dr. York for a further battery of tests. The
19 results of these examinations confirm that Mr. Brockman's impairment is progressive.

20 7. At this stage, Mr. Brockman may be oriented in time and place, aware of persons
21 in his company, able to engage in social conversation, and capable of functioning in familiar
22 tasks. However, Mr. Brockman's progressive dementia impairs his cognitive ability in several
23 respects. These include short term memory limitations. In addition, his condition renders long-
24 term memory inaccessible and defective. For these reasons, I concur with the medical position
25 that Mr. Brockman cannot assist his attorneys in his defense.

26 8. I understand that Mr. Brockman's counsel will make a motion for a hearing to
27 determine that Mr. Brockman cannot assist in his defense, and that this motion will be supported
28 by the medical reports and letters previously provided to them by me, Dr. Jankovic, Dr. Yu, and

1 Dr. York. I also understand that counsel will want to present testimony from each of us to
2 explain how we reached our conclusions. We are all based in Houston. Under ordinary
3 circumstances, it would be difficult for us to be present for a hearing in San Francisco, where this
4 court is located. Under the current circumstances of the COVID-19 pandemic, we would be
5 confronted with the increased risk of exposure at a time when the Centers for Disease Control and
6 Prevention and other medical advisors are counseling against travel, the potential need to
7 quarantine before and after travel, and the detrimental impact any absence or illness may have on
8 our other patients.

9 9. It is also not medically advisable for Mr. Brockman to travel to San Francisco for a
10 hearing or for trial. Mr. Brockman is 79 years old and suffers from underlying medical
11 conditions that put him at increased risk for severe illness if he were to contract COVID-19.

12 10. Additionally, requiring Mr. Brockman to face legal proceedings in a location
13 distant from his home will be disorienting in a manner that could accelerate the deterioration of
14 his mental condition. Unfamiliar environments, stimulating surroundings, and changes in routine
15 would be especially stressful for a person with Mr. Brockman's diminished capacity, creating a
16 risk to his existing cardiac condition, and could exacerbate the overall progression of his
17 symptoms.

18 11. Based on the foregoing, I respectfully submit this Declaration in support of Mr.
19 Brockman's Motion to Transfer Proceedings to the United States District Court for the Southern
20 District of Texas.

21 12. I declare under penalty of perjury that the foregoing is true and correct.

22
23 Executed in Houston, Texas on November 25, 2020.

24
25
26 
27 James L. Pool, M.D.
28

EXHIBIT H

Brockman, Robert Theron

MRN: 0300937767

Office Visit 1/30/2019 Provider: Jankovic, Joseph, MD (Neurology)
Baylor College of Medicine - Primary diagnosis: PD (Parkinson's disease)
Neurology Associates Reason for Visit: Movement Disorder; Referred by Pool, James L, MD

Additional Documentation

Vitals: BP 136/79 (BP Location: left arm, Patient Position: Sitting, Cuff Size: regular) Pulse 53
Ht 6' 1" (1.854 m) BMI 25.07 kg/m² BSA 2.11 m² [More Vitals](#)
Flowsheets: MDS UPDRS
Encounter Info: [Billing Info](#), [History](#), [Allergies](#), [Detailed Report](#)

Media

[Scan on 1/31/2019 9:44 AM by Garcia, Karen, CMA: Montreal Cognitive Assessment \(MOCA \)](#)

Progress notes

Savitt, Daniel, DO at 2/8/2019 1:50 PM

Author Type: Fellow Status: Addendum
Editor: Savitt, Daniel, DO (Fellow)

PT NAME: Robert Theron Brockman
MRN: 0300937767
DOB: [REDACTED]

INITIAL NEUROLOGICAL EVALUATION: 1/30/2019

REFERRING PHYSICIAN: Pool, James L, MD and Stuart Yudofsky, MD

REASON FOR EVALUATION:

We had the pleasure of evaluating Mr. Brockman at the Parkinson's Disease Center and Movement Disorders Clinic at Baylor College of Medicine on 1/30/2019. He presents for evaluation and treatment of Parkinson's disease.

HISTORY OF PRESENT ILLNESS:

Mr. Brockman is a 77 year old ambidextrous man, the CEO of a computer software company, who presents for evaluation of possible Parkinson's disease.

The onset of symptoms began 1.5 years ago with concentration and memory difficulty. He developed depressive symptoms about 6 months ago for which bupropion was started 2 months ago. Since that time, he has noticed an improvement in his thinking and memory. He also noticed difficulty with his balance about 1.5 years ago. For example, he enjoys fly-fishing as a hobby and has more difficulty standing even in calm waters. He takes shorter steps and has a stooped posture with walking. There is no freezing and no change in his arm swing.

He has stiffness when he does not exercise. He is moving more slowly in general as well. His handwriting is messier and smaller and for this reason, he has stopped signing employee certificates. He has not noticed a significant tremor. He has some difficulty with

tasks requiring fine motor movements such as buttoning certain buttons and starting the line for his fly-fishing.

He has developed near absence of sense of smell about 10 years ago. He also began acting out his dreams at nighttime 2-3 years ago, kicking and punching in his sleep. He generally sleeps well, although recent work stress has disrupted his sleep and he now takes melatonin. He has increased urinary frequency (he goes hourly) and urgency but without incontinence or retention. He had constipation when he started Cardizem 2.5 years ago, that resolved with stool softeners. He does not have hypophonia but his wife notices slower speech. He has excessive salivation. For the past 6-8 months, he has had difficulty swallowing food and medications, coughs with swallowing. He has reduction in his hearing but does not want to wear hearing aids.

He has never been prescribed antiemetics or antipsychotics and has never been treated for these symptoms.

DIAGNOSTIC TESTS:

MRI brain (11/2/19): Unremarkable

RESPONSE TO TREATMENT:

None

ALLERGY: No Known Allergies

Current Outpatient Medications

| Medication | Sig | Dispense | Refill |
|---|---|----------|--------|
| • buPROPion (WELLBUTRIN SR) 100 MG SR tablet | Take 100 mg by mouth two times daily. 200mg each morning and 100mg each evening | | |
| • diltiazem (DILTIAZEM CD) 120 MG ER capsule | Take 120 mg by mouth daily. | | |
| • ELIQUIS 2.5 MG TABS | TAKE 1 TABLET TWICE DAILY | | 2 |
| • ezetimibe-simvastatin (VYTORIN) 10-40 MG per tablet | Take 1 Tab by mouth every evening. | | |
| • levothyroxine (SYNTHROID) 75 MCG tablet | Take 75 mcg by mouth daily. | | |
| • Multiple Vitamins-Minerals (MULTIVITAMIN ADULT OR) | Take by mouth. | | |
| • Testosterone (ANDROGEL) 50 MG/5GM GEL | Place onto the skin. | | |

No current facility-administered medications for this visit.

PAST MEDICAL HISTORY:

Past Medical History:

Diagnosis

Date

- Atrial fibrillation

- Basal cell carcinoma
- Bladder cancer
- Depression
- Hypercholesteremia
- Melanoma
- Ocular migraine 1/2012
lasted ~30 minutes
- Prostatitis 1980
- Prostatitis
- Pseudoexfoliation glaucoma(365.52)
- Thyroid disease
- UTI (lower urinary tract infection)

PAST SURGICAL HISTORY:

Past Surgical History:

| Procedure | Laterality | Date |
|--|------------|------|
| • HX BLADDER TUMOR EXCISION | | 2006 |
| • HX DENTAL SURGERY <i>infected tooth</i> | | |
| • HX TONSILLECTOMY | | 1945 |

FAMILY HISTORY:

Heritage: Caucasian

Mother: Diabetes. She had a mediastinal mass that was inoperable (possibly lymphoma) but deferred treatment.

Father: COPD

There is no family history of Parkinson's disease or tremor.

SOCIAL HISTORY:

Marital Status: Married

Education: 1 year of graduate school

Occupation: CEO/founder of a computer software company

Lives with his wife.

Social History

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance Use Topics

- Alcohol use: Yes

REVIEW OF SYSTEMS:

GENERAL: The patient denies fevers, chills, weight loss, or weight gain.

EYES: The patient denies dry eyes, blurry vision, double vision, or vision loss.

EARS/NOSE/THROAT: The patient denies hearing loss, voice changes, rhinorrhea, dry mouth, or sore throat.

CARDIOVASCULAR: The patient denies chest pain, palpitations, irregular heartbeat, or lightheadedness.

RESPIRATORY: The patient denies cough, shortness of breath, or asthma.

GI: The patient denies nausea, vomiting, diarrhea, constipation, bowel incontinence, ulcers, or reflux.

GU: The patient denies bladder incontinence, dysuria, urinary urgency, or frequency.
HEME: The patient denies anemia, easy bruising, easy bleeding, or a clotting disorder.
DERMATOLOGIC: The patient denies rash, suspicious lesions, or change in skin color.
ENDOCRINE: Patient denies heat or cold intolerance, hair loss, diabetes, or thyroid problems.
MUSCULOSKELETAL: The patient denies joint or back pain, joint swelling, arthritis, ankle swelling, or muscle aches.
PSYCHIATRIC: The patient denies hallucinations, delusions, insomnia, or a history of bipolar disorder, OCD, ADD, ADHD. The patient has depression, anxiety, and memory loss.
NEUROLOGIC: The patient denies tremor, headaches, seizures, strokes, paresthesias, weakness, or sexual dysfunction. The patient has stiffness, gait imbalance, and hearing abnormalities.

PHYSICAL EXAMINATION:

Sitting

Vitals:

01/30/19 0911
 BP: 136/79
 BP Location: left arm
 Patient: Sitting
 Position:
 Cuff Size: regular
 Pulse: 53
 Height: 6' 1" (1.854 m)

General: The patient is well appearing and in no distress.
Skin: No rashes.
HEENT: Normocephalic and atraumatic.
Neck: Supple to palpation.
Cardiovascular: Regular rate and rhythm.
Lungs: Clear to auscultation bilaterally.
Peripheral Vascular System: No edema and normal distal pulses.
Abdomen: Nontender, soft.
Extremities: No cyanosis or edema.
Visual: No visual field abnormalities.
Psychiatric: There is appropriate mood and affect.
Musculoskeletal: No arthritic signs.

NEUROLOGICAL EXAMINATION:

Mental Status: The patient is alert and oriented to person, time, and place. Speech is fluent with good comprehension. There are no abnormal perceptions, hallucinations, delusions, or illusions. The patient is able to follow three-step commands. There is no right/left disorientation, ideomotor or constructional apraxia, or evidence of ADHD or OCD. A MoCA examination was administered and the patient received a score of 19/30.
Cranial Nerve Examination: Pupils are equal, round, and reactive to light. Visual fields are full. Non-dilated fundoscopic examination revealed normal retinal and vascular anatomy. No evidence of Kayser-Fleischer rings. Ocular movements are full with no evidence of nystagmus or abnormal saccades. There are no square-wave jerks. Normal light touch within the distribution of the fifth cranial nerve. No facial asymmetry or dysarthria. Hearing is normal to finger rub bilaterally. Tongue and palate are in the midline. 5/5 trapezius strength.

Motor Examination: The patient has normal bulk, and 5/5 strength in the upper and lower extremities.

Rigidity: 2+ in each leg.

Bradykinesia: Mild bradykinesia worse on the right.

Involuntary Movements: There is no evidence of myoclonus, tics, chorea, or dystonic postures.

Tremor: 2+ kinetic tremor and 1+ postural tremor in each arm.

Reflexes: 2/4 and symmetric in the biceps, triceps, brachioradialis, quadriceps, and ankle jerks. Plantar response is flexor.

Sensation: Normal to joint position, temperature, light touch, and vibration in all the extremities.

Coordination: The patient has normal finger-nose-finger and heel-to-shin. There is no evidence of dysdiadochokinesis with rapid alternating movements.

Gait, Balance and Posture: The patient is able to arise from a chair without hesitation. There is reduced stride length, stooped posture, absent arm swing and en bloc turning. Romberg is normal. There is 1+ postural instability.

Rating Scales: MDS- UPDRS was completed in the electronic chart.

IMPRESSION: Mr. Brockman is a 77 year old ambidextrous man, the CEO of a computer software company, who presents for evaluation of Parkinson's disease. The onset of symptoms began 1.5 years ago with walking and balance difficulty. He developed shorter steps, stooped posture, and more difficulty maintaining balance, especially when standing in water while fishing. He has also noticed slowness of movement, difficulty with dexterity, micrographia, anosmia, and dream-acting behavior (REM-Behavioral Disorder). He had an MRI brain in 11/2018 that was unremarkable. His examination is significant for a MoCA of 19/30, 2+ leg rigidity, mild bradykinesia, and a parkinsonian gait. His history and examination are consistent with the diagnosis of postural instability gait difficulty (PIGD) type Parkinson's disease. Vascular parkinsonism is also a possible consideration given his lower body predominant symptoms and presence of vascular risk factors that include atrial fibrillation hypertension, and hyperlipidemia.

RECOMMENDATIONS:

1. The diagnosis of Parkinson's disease or possible vascular parkinsonism was discussed with the patient and his wife.
2. An information packet was provided about Parkinson's disease.
3. The following tests were requested:
 - DaTscan to evaluate for dopaminergic deficiency and differentiate between vascular parkinsonism and idiopathic Parkinson's disease.
 - Has appointment scheduled for neuropsychiatric testing.
 - Will place referral to Stromatt driving evaluation due to concerns for safety with driving.
4. We prescribed the following medications and treatments:
 - Start carbidopa/levodopa 25/100 and titrate to 2 tablets three times daily. Written titration instructions were provided.
5. We would like to see the patient for follow-up in 4 months.

We discussed with the patient the indications and potential side effects of the prescribed treatment.

I personally interviewed and examined the patient, and agree with the above report. It has been our privilege to evaluate this patient.

This report was electronically signed by:
 Joseph Jankovic, M.D./ Daniel Savitt, D.O.
 Professor of Neurology/ Movement Disorders Fellow

Joseph Jankovic, MD
Professor of Neurology
Distinguished Chair in Movement Disorders
Director, Parkinson's Disease Center
and Movement Disorders Clinic
Baylor College of Medicine
Department of Neurology
Baylor St. Luke's Medical Center at the McNair Campus
7200 Cambridge, 9th Floor, Suite 9A
Houston, TX 77030-4202
Tel: 713-798-2273
www.jankovic.org

cc:
Dr. James Poole
6620 Main St.
Houston, TX 77030
713-798-0180

Dr. Stuart Yudofsky
1 Baylor Plz #115D
Houston, TX 77030
713-798-4945

Revision History

Jankovic, Joseph, MD at 1/30/2019 11:16 AM

Author Type: Physician Status: Signed

Editor: Jankovic, Joseph, MD (Physician)

I personally saw and evaluated the patient, and reviewed the Vitals, History, Allergies and Medications sections of the electronic medical record. I agree with the findings as written by the fellow, resident, nurse practitioner.

JOSEPH JANKOVIC, M.D.
Professor of Neurology
Distinguished Chair in Movement Disorders
Director, Parkinson's Disease Center
and Movement Disorders Clinic
Baylor College of Medicine
Department of Neurology
7200 Cambridge, Suite 9A, MS: BCM 609
Houston, TX 77030-4202
Tel: 713-798-2273 or -6556

Fax: 713-798-6808

Web: www.jankovic.org

No questionnaires available.

Patient Instructions

1. We discussed the diagnosis of Parkinson's disease.
2. We ordered a DaTscan to evaluate for dopamine deficiency related to Parkinson's disease.
3. You have been prescribed Sinemet 25/100mg tablets.
 - Please take this medication with food unless otherwise instructed.
 - Common potential side effects may include nausea, sleepiness, dizziness, or hallucinations.
 Please call 713-798-7438 if you experience these or other side effects.

| | BRKFST | LUNCH | DINNER |
|--------|--------|-------|--------|
| WEEK 1 | 1 | | 1 |
| WEEK 2 | 1 | 1 | 1 |
| WEEK 3 | 2 | 2 | 2 |

4. We will also send a referral for an independent driving evaluation.

AVS Reports

| Date/Time | Report | Action | User |
|-----------------------|---------------------|-------------------------|----------------------|
| 1/30/2019 11:27 AM | After Visit Summary | Printed | Savitt, Daniel, DO |
| 1/30/2019 11:16 AM | After Visit Summary | Automatically Generated | Jankovic, Joseph, MD |

Follow-up and Disposition

Return in about 3 months (around 4/30/2019).

Orders Placed

NM DATSCAN BRAIN SPECT (Resulted 2/14/2019)

Medication Changes

As of 1/30/2019 11:27 AM

| | Refills | Start Date | End Date |
|--|---------|------------|----------|
| Added: carbidopa-levodopa (SINEMET) 25-100 MG per tablet Take 2 Tabs by mouth 3 times daily. - ORAL | 1 | 1/30/2019 | |
| Apixaban Discontinued or Completed: Apixaban (ELIQUIS OR) | | | |

| | Refills | Start Date | End Date |
|--|---------|------------|----------|
| Unchanged: ELIQUIS 2.5 MG TABS TAKE 1 TABLET TWICE DAILY | 2 | 8/4/2018 | |
| Discontinued or Completed: diltiazem (CARDIZEM SR) 60 MG SR capsule | | | |
| Discontinued or Completed: doxycycline (VIBRAMYCIN) 100 MG capsule | | | |
| Discontinued or Completed: levofloxacin (LEVAQUIN) 750 MG tablet | | | |
| Discontinued or Completed: Metoprolol Succinate (TOPROL XL OR) | | | |
| Discontinued or Completed: nitrofurantoin (MACRODANTIN) 100 MG capsule | | | |

Visit Diagnoses

PD (Parkinson's disease) G20
 Cognitive decline R41.89
 RBD (REM behavioral disorder) G47.52

EXHIBIT I



Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist
 Associate Professor
 Department of Neurology

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Robert Brockman
 Date of Birth (Age): [REDACTED] 77 yr.)
 Date(s) of Evaluation: 03/01/2019
 Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor
 Referred by: James Pool, MD
 Referral Question: Differential Diagnosis
 CPT Code: 96116 (60 mins) 96121 (120 mins) 96136 (30 mins) 96137 (180 mins) 96132 (60 mins)
 96133 (180 mins)

BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 77 year-old, right-hand dominant, Caucasian male with a two to three year history of short-term memory loss. He was referred by his physician for neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning with the aim of informing medical differential diagnosis and facilitating clinical decision making. The following information was obtained during a clinical interview with Mr. Brockman and from available medical records.

Current Concerns and General Condition: Mr. Brockman and his spouse participated in the clinical interview. He was able to act as a reliable informant. Mr. Brockman reported declines in his short-term memory over the past 2 to 3 years. He reported that he is repeating himself, losing possession, and losing his train of thought and is more tangential. He forgets names of new individual and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and has hit curbs while driving and parking. He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking.

Mr. Brockman reported that he began taking Wellbutrin which has improved his mood. He noted that "It is clear that he is working too much." He denied anhedonia, depressed mood, heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he is a night owl and dozes off during the day. His wife reported that he began to act out his dreams a couple of years ago. He has decreased appetite and has lost weight. His wife noted that he does not speak as much. He reported that he has floaters in his visual fields. He denied visual hallucinations, but it is noted that later he pointed out a bug on the testing room floor that was not present to either the examiner or his wife.

Medical History: Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, tremor, micrographia, and back problems. He currently has plantar fasciitis, so he is not walking for exercise. He reported that he was hospitalized for a prostate infection four years ago and pericarditis. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa one month ago. His wife noted an improvement when he first started on the medication, but since the medication was increased, she reported that he has increasing clumsiness. He is scheduled to be evaluated by Dr. Jankovic for his movement disorder. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION
 Brockman, Robert

Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist
 Associate Professor
 Department of Neurology

history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. He has been taking bupropion for two months, which has reportedly improved his mood significantly. He is taking trazodone to aid his sleep and reducing his REM Behavior Disorder. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines. Please refer to his chart for a listing of his current medications. He is on a large regimen of supplements and vitamins.

Social History: Mr. Brockman has been married for 50 years and they have one son. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

Behavioral Observations: Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his spouse who participated in the clinical interview. General appearance was neat and clean. He exhibited shuffling and slow gait, slowed motor behavior, and a right hand tremor. His mood was neutral, and he had a flat affect. He had a masked face. Eye movements were normal. Vision (with corrective lenses) and hearing were adequate for the testing session. Conversational speech was coherent and goal-directed, but it was sparse with short phrases. There was no evidence of paraphasias. He evidenced a slight stutter at times. He showed moderately decreased ability to follow directions, and he frequently needed repetition of directions and to be reoriented to task. He perseverated to previous tasks. The examiner needed to be concrete for him to understand the task instructions. His processing speed was extremely slow. He was cooperative but evidenced surrendering test-taking behavior. His attitude towards the examiner was appropriate and friendly. He lacked insight into his cognitive problems. During testing, the patient said he was not doing well, but he appeared very surprised. His handwriting was micrographic. He saw a bug on the floor of the testing room that was not present. The following results are thought to be an accurate estimation of his current cognitive abilities.

MEASURES ADMINISTERED

Montréal Cognitive Assessment (MoCA); Caregiver Neuropsychiatric Inventory (NPI-Q); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVLTR); Neuropsychological Assessment Battery (NAB subtest: Naming); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Fluency Test; Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Test of Premorbid Functioning (TOPF); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition); Instrumental Activities of Daily Living Scale (IADLS); Lawton and Brody Physical Self-Maintenance Scale (PSMS). Clinical Interview with patient and his spouse.

Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) and Wisconsin Card Sorting Test (WCST) measures due to cognitive/behavioral problems.

Informant questionnaires were sent home and completed by the patient's spouse. They were not returned by the time of the evaluation.

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION
 Brockman, Robert

Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist
 Associate Professor
 Department of Neurology

NEUROPSYCHOLOGICAL FINDINGS

The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).

Mental Status: Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is below expectation. He was oriented (6/6) and short-term recall was 2/5. He was aided by category cueing for one word. He demonstrated difficulties with set shifting, drawing a cube, drawing a clock face with numbers and hands placed accurately, repeating one sentence, and with serial 7's and verbal fluency.

Intellectual: Premorbid level of intellectual functioning was estimated to be in the high average range (TOPF SS=114), based on single, atypical word reading skills. Mr. Brockman noted that the first word presented for him to read aloud was not a word ("two"). He was able to state the letters, but noted that he did not think that was a word and then stated he guessed it was two. Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from borderline to high average yielding a pro-rated Full Scale IQ estimate of 87, which is in the low average range.

Attention/Concentration: Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was low average with 7 digits forward, 3 digits backward, and 2 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was borderline impaired. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was borderline impaired with 0 errors.

Executive: Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was deficient. His abstract verbal reasoning was high average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued.

Memory: Recall of culturally-based general knowledge was average. Immediate recall of verbally presented contextual material was deficient (SS=3). Delayed recall of the stories was deficient (SS=3). Retention of initially learned material was 11.1%. Recognition memory was average (16/23). Mr. Brockman began describing the WMS VR figures during LM immediate recall. Incremental learning for a semantically-categorized word list across 3 trials was borderline impaired (2, 5, and 6 words per trial), and delayed recall was in the deficient range with 0.0% retention which falls within the deficient range. On recognition memory assessment, 9/12 target words were correctly identified, 5 false positive errors were committed, with discrimination accuracy in the deficient range.

Immediate recall of basic geometric figures was deficient (SS=1). Delayed recall of the designs was deficient (SS=2). Retention of the initially learned material was 0.0%. Recognition memory was borderline impaired (1/7).

Language: Lexical fluency was low average with between 9 and 13 words per trial. Semantic fluency was deficient with 8 exemplars generated. Confrontation naming of pictured objects was average (29/31).

Visual-Perceptual: His drawing of a complex geometric design scored in the deficient range. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was impaired

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION
 Brockman, Robert

Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist
 Associate Professor
 Department of Neurology

to command (CDT=3/10). He drew a micrographic clock face. The examiner produced a clock face for him, but he was unable to place the numbers accurately and drew a hand to the 10 and the 6 for 10 after 11. His copy of a clock was also impaired (CDT=6/10). He drew the clock face but the numbers were drawn in only the right side of the face and the hand size differentiation was not maintained.

Mood / Personality: On a self-report measure of anxiety, his responses fell in the mild range (GAD-7=7/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of within normal limits (GDS=8): boredom, feeling as though something negative is going to occur, preferring to stay home, worry about the future, declines in memory, poor energy, difficulties with concentration, and preferring to avoid social gatherings.

Activities of Daily Living: His spouse served as the informant completing a questionnaire regarding the patient's ability to complete basic and instrumental activities of daily living. Mr. Brockman reportedly has difficulties with self-care ADLs (PSMS=7/30) including ambulation. He requires mild assistance with instrumental activities of daily living (IADLs=9/31), most notably housekeeping. Although his wife did not report many functional declines, Mr. Brockman requires mild aid with his more complex ADLs.

Neurobehavioral: The patient's spouse completed an inventory assessing for the presence of neurobehavioral symptoms commonly associated with dementia, reportedly observing mild problems with agitation, anxiety, apathy, irritability, nighttime behaviors, and changes in appetite with moderate depression (NPI-Q severity=8; distress=11) which produce an overall minimal level of familial distress, with the exception of his depression and agitation which produces moderate distress.

SUMMARY AND IMPRESSION

Mr. Brockman is a 77 year-old, right-hand dominant, Caucasian male who was referred by his physician for evaluation of his current neuropsychological, behavioral, and emotional status. He currently operates in the low average range of general intellectual functioning (WAIS-IV FSIQ=87), which is a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, and changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produces moderate distress.

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuoconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming,

This pattern of neuropsychological performance indicates a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. To my knowledge, Mr. Brockman has not been diagnosed with a movement disorder. However, he demonstrates movements that may be consistent with a Parkinsonism. These

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION
 Brockman, Robert

Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist
 Associate Professor
 Department of Neurology

abnormal movements taken together with his current diagnosis of dementia, new onset visual hallucinations and potential visual illusions, and REM Behavior Disorder, his pattern of cognitive impairments is consistent with Dementia with Lewy Bodies.

RECOMMENDATIONS

General:

- Mr. Brockman and his family should receive feedback regarding his current level of cognitive functioning.
- Continued pharmacologic treatment of his depression appears warranted.
- Mr. Brockman should be monitored for episodes of visual hallucinations. Although he did not report hallucinations on interview, he saw a bug on the floor in the testing room which was not present.
- You may wish to consider referring the patient and his family to psychoeducational counseling with the goal of developing appropriate coping strategies, maximization of current strengths to mitigate identified weaknesses, and assist in future life planning.
- Mr. Brockman does not pose a significant safety risk and as such, he should receive occasional supervision for self-care ADLs for safety and to monitor for future changes in his ability status. He should also receive occasional review of instrumental activities of daily living to monitor for future changes in his ability status, particularly for medication and personal financial management.

Memory Compensatory Strategies:

- Mr. Brockman should exercise caution when operating potentially dangerous household appliances (e.g., stove/range, irons, food processors, etc.). Using models with automatic shut-off features would be ideal.
- Mr. Brockman should refrain from cooking activities involving potentially dangerous appliances (e.g., stove, food processor, etc.).
- The use of a smartphone is recommended for recording important information, setting reminders, and is maintaining and organized schedule. Applications such as Google calendar, Remember the Milk, and the Reminders application for the iPhone or similar techniques may be helpful.
- It may be helpful to have a mobile phone or smartphone with him to allow easy access to telephone number he could contact in an emergency or when he cannot recall this information.
- Placing a large-type calendar or clock that includes the date in a highly visible location may assist him in maintaining better temporal orientation.
- The patient may benefit from the placement of a large dry-erase board in a prominent spot in the home where important information can be posted such as the date, the day's or week's schedule, the whereabouts of his spouse/family members, their time to return, or important telephone numbers.
- The patient's family may wish to consider presenting important information that Mr. Brockman needs to recall in a written format when possible to allow him to refer to and review the information as necessary.
- Mr. Brockman and his family should consider establishing a 'memory station' where he would consistently place personal items such as his keys, checkbook/wallet, glasses, etc. to help prevent future memory failures regarding lost objects and to reduce anxiety and misattributions regarding the occurrence of these events. He is also encouraged to use external memory aids such as shopping lists, calendars, timers, a pill minder, and "to do" lists whenever possible to mitigate common, everyday memory failures.
- To the extent possible, he should try to avoid distracting environments when performing detailed tasks such as financial management. Breaking tasks down into more manageable units to prevent overtaxing attentional resources is another possibility. In this way, a large task can be achieved a little at a time over a week instead of an overwhelming task all in one evening, for instance.

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION
 Brockman, Robert

Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist
 Associate Professor
 Department of Neurology

Social Activities and Other Intellectual Stimulation:

- The patient is encouraged to maintain or increase (to the extent safely possible) his current level of intellectual and physical stimulation to help improve stamina, buoy his mood, and maintain his current level of quality of life.
- Mr. Brockman may benefit from engaging in intellectual stimulation such as reading, assembling jigsaw puzzles, and other activities such as word search puzzles, crosswords, or Sudoku. Computer-based activities such as www.Lumosity.com or www.happyneuron-corp.com are options as well. Board games and familiar card or other games (e.g., dominoes, bridge, solitaire, etc.) may also be enjoyable.
- Regular physical exercise is recommended for its beneficial effects on brain health and cognitive maintenance.

Driving:

- Neuropsychological tests are an imperfect predictor of real-world driving abilities; however, given his deficits in memory, attention/concentration, executive functions, visuospatial abilities, and his recent diagnosis of DLB, he should be encouraged to discontinue driving given concerns over his safety, that of others on the roadways, and legal liability issues that could arise for the patient should he become involved in a motor vehicle crash.

Legal:

- If not already in place, a family member should obtain Durable Power of Attorney for healthcare and financial matters.

Patient and Caregiver Resources:

- The Alzheimer's Association (www.alz.org/texas; 713-314-1314) provides useful information and resources for family members of patients with Alzheimer's and other types of dementia.
- Mr. Brockman and his family may benefit from community resources for seniors in the Houston area at www.HoustonTx.gov/Health/Aging and through the Houston Area Parkinson's Society (hapsonline.org).

The current results will be useful as a baseline to which findings from subsequent evaluations may be compared. Neuropsychological re-evaluation is recommended in one year (or sooner if his condition appears to change rapidly or if he and/or his family have additional concerns) to monitor neuropsychological, mood, and personality changes and to update recommendations.

Thank you for allowing me to participate in the care of Mr. Brockman. Please do not hesitate to contact me if you have any further questions.

Michele K York, PhD

Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist

N.B. This assessment was conducted as a clinical evaluation and not as a forensic assessment. This fact was verbally confirmed with the patient at the outset of testing.

EXHIBIT J

Brockman, Robert Theron


MRN: 0300937767

Office Visit 3/20/2019 Provider: Yu, Melissa, MD (Neurology)
Baylor College of Medicine Primary diagnosis: Dementia with Parkinsonism
Neurology Reason for Visit: Memory Loss; Referred by Pool, James L, MD

Additional Documentation

Vitals: BP 135/70 (BP Location: left arm, Patient Position: Standing) Pulse 58
Ht 5' 11.75" (1.822 m) Wt 189 lb (85.7 kg) BMI 25.81 kg/m² BSA 2.08 m² More Vitals
Flowsheets: Mini-Mental State
Encounter Info: Billing Info, History, Allergies, Detailed Report

Communications

 Chart Routed to Pool, James L, MD

Media

Scan on 3/19/2019 9:30 AM by Hudson, Kendra: ADMDC Packet
Scan on 3/20/2019 2:35 PM by Seedanee, Demonica: Clocks

Progress notes

Yu, Melissa, MD at 3/20/2019 4:58 PM

Author Type: Physician Status: Signed
Editor: Yu, Melissa, MD (Physician)

Consult requested by: James L Pool, MD
1977 Butler Blvd
Suite E6.150
Houston, TX 77030

Chief Concern:

Chief Complaint

Patient presents with

- Memory Loss

HPI:

Robert Theron Brockman is a 77 y.o. male who presents for evaluation of memory loss with his husband and his son.

Memory loss is reported beginning at least back to November 2017 in a Fondren Orthopedics progress note scanned into the chart.

He was recently seen in the PDMDC by Dr. Jankovic at which time he reported a 1.5 year history of cognitive difficulty along with balance difficulty. Anosmia was noted dating back about 10 years, and dream enactment behavior for the past 3 years. Increased tone and tremor was noted as well as reduced arm swing and stride length. Parkinson's disease was

suspected and DATSCAN was performed showing significant loss of dopaminergic signal. He was started on sinemet with motor improvement and started on Exelon patch on 3/13.

He now presents for memory disorders evaluation. He reports always having "superior memory." He reports onset of symptoms about 2 years ago. His wife reports some symptoms about 3 years ago with "slowing down" and then symptoms became much more obvious about 9 months ago associated with a stressful life event. His son notes that he repeats himself at times. He reports mild progression since that time.

He reports always misplacing objects. He reports minimal word finding issues but difficulty with spelling. He reports minimal difficulty with names. He reports some difficulty remembering to take his medications. He has stopped driving at his physician's request. No driving incidents were reported but his wife notes that he drives slower. He reports no trouble managing finances. He never cooks. He notes some difficulty with planning out tasks at work, family notes that he doesn't initiate activity like he used to.

He lost his sense of smell about 10 years ago. He describes his mood as "pretty good" but notes feeling shaken about his neuropsychological test results. His son reports that his ability fluctuates (he's had him draw clocks at various times). He reports episodes of "blankness" associated with less interaction alternating with improved cognition. His son notes significant fluctuations in terms of his decision making abilities, with good days and bad days. His son reports he's not as angry as he used to be.

The patient reports good sleep. At least four episodes of dream enactment behavior is reported and snoring - both have improved with trazodone. He reports awakening feeling refreshed. He does not nap. His family notes he has been more fatigued since being on diltiazem. He sleeps 7-8 hours/night.

He reports one episode of visual disturbance - saw a rainbow/possible visual aura about 8 years ago. No other visual phenomena are reported with the exception of a possible hallucination during neuropsychological testing - wife notes it was a "bad day". No auditory hallucinations are reported.

Motor symptoms began a few years ago with a stooped posture noted by his son. His son also noted increased tone in his back. His gait began to deteriorate in July 2018. He reports no falls. He reports urgency and frequency of urine but no incontinence. He reports some decline in his handwriting and family notes micrographia and decreased facial expression. He reports no sensory changes with the exception of mild tingling in two toes. No visual agnosia is reported.

Gait symptoms improved some with levodopa, particularly on one tab TID. Increase in dose to two tabs TID led to more cognitive decline but family reports he seems to have stabilized in this regard. Cognitively he has improved some with the Exelon patch as well. He reports minimal side effects except feeling spacy at times.

Past Neurological History:

History of Learning Disability: absent. BS Business. CEO and owner of large automotive dealership software company.

Previous diagnosis of neurological disease: None

Illness which could affect mentation: None

History of head injury: None

History of visual symptoms: as above

History of hearing symptoms: Decreased Acuity Both. Date of onset: uncertain

History of abnormal movements: None

Previous stroke or TIA: None

Previous seizure: None

Past Medical History:

Past Medical History:

| Diagnosis | Date |
|---------------------------------------|--------|
| • Atrial fibrillation | 2016 |
| • Basal cell carcinoma | |
| • Bladder cancer | |
| • Depression | |
| • Hypercholesteremia | |
| • Melanoma | |
| • Ocular migraine | 1/2012 |
| <i>lasted ~30 minutes</i> | |
| • Prostatitis | 1980 |
| • Prostatitis | |
| • Pseudoexfoliation glaucoma(365.52) | |
| • Thyroid disease | |
| • UTI (lower urinary tract infection) | |

Past Surgical History:

Past Surgical History:

| Procedure | Laterality | Date |
|--|------------|------|
| • HX BLADDER TUMOR EXCISION | | 2006 |
| • HX CATARACT REMOVAL | | |
| • HX DENTAL SURGERY <i>infected tooth</i> | | |
| • HX TONSILLECTOMY | | 1945 |

Allergies:

No Known Allergies

Medications:

| | |
|---|--|
| • buPROPion (WELLBUTRIN SR) 100 MG SR tablet | Take 100 mg by mouth two times daily. 200mg each morning and 100mg each evening |
| • carbidopa-levodopa (SINEMET) 25-100 MG per tablet | Take 2 Tabs by mouth 3 times daily. |
| • diltiazem (DILTIAZEM CD) 120 MG ER capsule | Take 120 mg by mouth daily. |
| • ELIQUIS 2.5 MG TABS | TAKE 1 TABLET TWICE DAILY |
| • ezetimibe-simvastatin (VYTORIN) 10-40 MG per tablet | Take 1 Tab by mouth every evening. |
| • levothyroxine (SYNTHROID) 75 MCG tablet | Take 75 mcg by mouth daily. |
| • rivastigmine (EXELON) 4.6 MG/24HR PT24 | Apply 1 patch to skin every 24 hrs x 1 month then increase to 2 patches thereafter |

- Testosterone (ANDROGEL) 50 MG/5GM Place onto the skin.
GEL
- trazodone (DESYREL) 50 MG tablet Take 1 Tab by mouth at bedtime.

Social History:
Social History

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance Use Topics

- Alcohol use: No
Frequency: Never
Comment: none for 3 years, previous occasional heavy drinking (not regularly)
- Drug use: No

Occupation: As above

Marital Status: Married, one son who is Neuroscience graduate student

Family History:

Family History

| Problem | Relation | Name | Age of Onset |
|---------------------|----------|------|--------------|
| • Lymphoma | Mother | | |
| • COPD | Father | | |
| • Other (aspergers) | Brother | | |

Neurological disorders: as above

Review of Systems: see health assessment - reviewed with patient

Constitutional: No weight change, fever, chills, fatigue

Eyes: No diplopia, blurry vision, dry eyes, cataracts, macular degeneration except history of cataract removal

ENT: No headache, sinus issues, hearing loss, tinnitus, dry mouth, vertigo except hearing loss reported

Cardiovascular: No chest pain, tachycardia, bradycardia. Reports history of angina.

Respiratory: No difficulty breathing

GI: No abdominal pain, constipation/diarrhea, nausea, incontinence

GU: No pain on urination, incontinence, kidney stones. Reports history of bladder cancer, occasional incontinence

Skin/Teg: No rash, lacerations, easy bruising. Reports history of basal cell CA and melanoma.

Musculoskeletal: No significant neck or back pain, history of arthritis, broken bones except history of osteopenia and arthritis.

Psychiatric: No anxiety, reports history of depression

Endocrine: No thyroid abnormalities, DM except reports hypothyroidism on synthroid.

Hematologic: No anemia, transfusions

Immunologic: No recent infections

Neurologic: See above

Vital Signs:

Vitals:

| | | |
|-----------|---------------------|---------------|
| | 03/20/19 1304 | 03/20/19 1307 |
| BP: | 140/73 | 135/70 |
| BP | left arm | left arm |
| Location: | | |
| Patient | Sitting | Standing |
| Position: | | |
| Pulse: | 53 | 58 |
| Weight: | 189 lb (85.7 kg) | |
| Height: | 5' 11.75" (1.822 m) | |

General Physical Examination:

Gen: Well developed, well nourished in no apparent distress. Awake and alert.

Neck: supple, full range of motion. No carotid bruits

Cardiac: Rate and rhythm regular without any murmurs and with normal S1 and S2 sounds.

Chest: clear to auscultation, no wheezes, rales or rhonchi, symmetric air entry

Abdomen: soft, nontender, nondistended, no masses or organomegaly

Extremities: no pedal edema

Skin: Intact

NEUROLOGICAL EXAMINATION:

(120 mins post levodopa)

MMSE 26/30 (7s), 25/30 (spelling) Definite visual issues noted with significant issues noted drawing clock and intersecting pentagons.

Clock drawing 2/4 (circle, numbers, unable to indicate correct time. Numbers on outside of clock)

General behavior: cooperative. Repetitive.

Deficit Anosognosia: Minimizes

Judgement: fair, estimated from: history and observation

Apraxia: absent

Speech:

Spontaneous speech: normal

Comprehension: normal

Repetition: normal

Word finding difficulty: present

Dysarthria: absent

Cranial Nerves

II: Acuity deferred. VFF. Fundus: No papilledema

III, IV, VI: PERRL, EOMI, no nystagmus

V1-V3: intact to light touch bilaterally

VII: face symmetric

VIII: diminished to finger rub bilaterally

IX, X: palate elevates equally and symmetrically

XI: SCM 5/5

XII: tongue movements symmetric and midline. No fibrillations or atrophy.

General Motor Survey

Posture: stooped

Tone: increased in RUE with distraction

Atrophy: absent

Motor Examination

Power 5/5 throughout.

Deep Tendon Reflexes

| <u>DTRs</u> | Bic | Tric | BR | Pat | Ankle | Babinski |
|-------------|-----|------|----|-----|-------|----------|
| Right | 2+ | 2+ | 2+ | 1+ | 1+ | flexor |
| Left | 2+ | 2+ | 2+ | 1+ | 1+ | flexor |

Abnormal reflexes: glabellar and snout and jaw jerk

Sensory Examination

Vibration: Normal in both legs except decreased in the toes bilaterally

Joint Position: Normal in both legs except in the toes bilaterally

Light Touch: Normal in all 4 extremities

Pinprick: Normal in all 4 extremities

Coordination

Finger to nose: mild action tremor noted bilaterally

Heel to shin: Normal bilaterally

Movement:

Bradykinesia: slow rapid alternating movements noted bilaterally, more pronounced on left. Hypomimia and mild bradyphrenia noted.

Tremor: no rest tremor noted. Mild postural tremor noted in left more than right hand.

Other abnormal movements: Single myoclonic jerk (trunk) noted during examination

Gait and Station

Gait and posture: stooped posture with minimal arm swing, short steps with en bloc turning noted

Romberg testing: Normal

Posture: significant postural instability noted with minimal stimulus

Able to rise from chair without use of arms

Review of Medical Records:

Neuropsychological testing (3/1/19, York):

IMPRESSION: Pattern indicates a dementia of mild to moderate severity with deficits in areas of visuospatial functioning, verbal and nonverbal episodic memory and executive functioning, with mild functional declines. Parkinsonism combined with dementia, new onset visual hallucinations, potential visual illusions and REM Behavior disorder are consistent with dementia with Lewy Bodies. Driving cessation recommended.

Prior labs:

Normal: RPR, HIV, homocysteine, CMP, folate, B12, lipid panel, MMA, D, SPEP, A1C, TFTs, CBC, ESR

MRI of the brain 11/2018:

Patient Instructions

1. After one month, increase the patch to 9.5mg daily (new prescription)
 2. Go to physical therapy
 3. Kendra will call you to set up an appointment with Dr. Kenan
- Follow up with me is recommended in 3 months to see how you're doing.

AVS Reports

| Date/Time | Report | Action | User |
|----------------------|---------------------|---------|-----------------|
| 3/20/2019 2:33 PM | After Visit Summary | Printed | Yu, Melissa, MD |

Follow-up and Dispositions

- Return in about 3 months (around 6/20/2019).

Orders Placed

APOLIPOPROTEIN E MUTATION - CARDIAC (Resulted 3/20/2019)
AMB REF TO PT EXTERNAL Closed

Medication Changes

As of 3/20/2019 2:24 PM

| | Refills | Start Date | End Date |
|--|---------|------------|----------|
| Added: rivastigmine 9.5 MG/24HR PT24 Place 9.5 mg onto the skin daily. - Transdermal | 5 | 3/20/2019 | |
| traZODone HCl Discontinued or Completed: TRAZODONE HCL OR Unchanged: trazodone (DESYREL) 50 MG tablet 3 Take 1 Tab by mouth at bedtime. - ORAL | | 3/13/2019 | |

Visit Diagnoses

Dementia with Parkinsonism G31.83, F02.80

EXHIBIT K

BROCKMAN, ROBERT

Patient ID: 0300937767

DOB: [REDACTED]

Age: 78

Gender: M

Date: October 01, 2019

SCORE**TODAY****CLOCK DRAWING: TODAY**

3-WORD MEMORY

0

ORIENTATION

6

SEQUENCE MEMORY

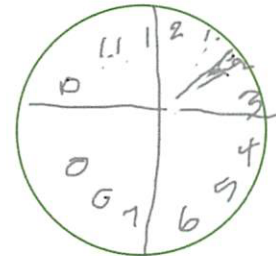
4

TIME

2

TOTAL SCORE

12

**Background**

This patient is a 78 year-old man who lives independently in the community. The patient's cognitive functioning is being evaluated due to cognitive complaints by the patient, a family member, or a community observer.

Test Results

This patient has received a score of 12 of 29 points. This score falls below the cutoff for dementia in patients of this age and educational level and is typically associated with Major Neurocognitive Disorder, moderate (formerly Moderate Dementia). In our research database of 3500 patients, no patients in this score range had normal cognition, 2% had Mild Cognitive Impairment (MCI), and 98% had dementia.

The test administrator agrees with the results of this test.

Results Over Time

12


October 2019

Plan

No plan.

BROCKMAN, ROBERT

Patient ID: 0300937767 DOB: [REDACTED] Age: 78 Gender: M



Donna Ansualda

Disclaimer: This test has high levels of sensitivity, specificity and reliability, but does not replace comprehensive neuropsychological and medical evaluation. Our recommendations are based on current research and extensive clinical experience with this population. The CogniSense™ tool has been validated in English speaking adults ages 60 to 92 in a community-based primary care setting.

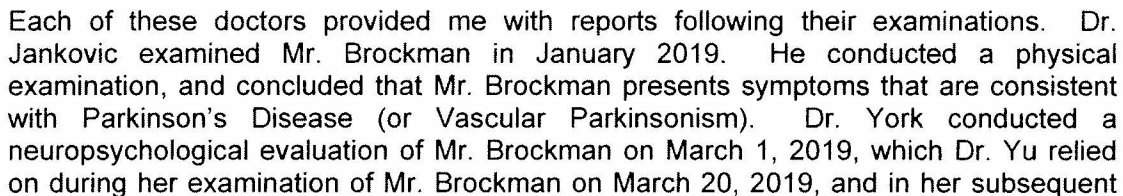
References:

Clionsky, M and Clionsky E, "Development and Validation of the Memory Orientation Screening Test," American Journal of Alzheimer's Disease & Other Dementias, 2010, 25 (8), 650-656

Clionsky, M and Clionsky E, "Identifying Cognitive Impairment in the Annual Wellness Visit: Who Can You Trust?," The Journal of Family Practice, 2011, 60: 653-659

Clionsky, M and Clionsky E, "The Memory Orientation Screening Test (MOST®) accurately separates normal from MCI and demented elders in a prevalence-stratified sample," Alzheimer's Disease & Parkinsonism, 2013, 3:1

EXHIBIT L



Re: Robert Theron Brockman (DOB [REDACTED])
Letter to Kathryn Keneally • January 14, 2020

Page 2

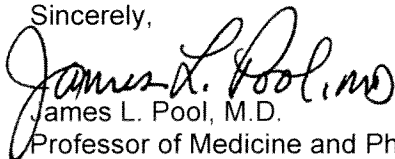
diagnosis. Dr. York and Dr. Yu concluded that Mr. Brockman's movements are consistent with Parkinson's Disease (or Vascular Parkinsonism). They also concluded his ongoing cognitive impairment is consistent with Lewy Body Dementia. These diagnoses cannot be totally confirmed except at autopsy of the brain after the death of the patient.

Parkinson's Disease (or Vascular Parkinsonism) and Lewy Body Dementia may each cause cognitive impairment and dementia. In Mr. Brockman's case, his recent neurological tests show mild to moderate dementia. In contrast to severe dementia, which will manifest as an inability of an individual to know where he is, what he is doing, or with whom he may be speaking, a person with mild to moderate dementia has some recognition of what is going on around him, and may function at a level at which he can cover-up his limitations. In a case such as Mr. Brockman, where an individual had superior, pre-morbid intelligence and functioned at a high level prior to the onset of dementia, he may be able to cover-up his limitations in social and business settings. In Mr. Brockman's case in particular, it became clear from my discussions with his wife and son that he has had a long-standing, excellent support network that enables him to appear to be continuing in his routine activities.

At this stage, Mr. Brockman has undeniable short-term memory limitations. Quite simply, if information is presented to him, he will be unable to comprehend what is being asked of him and to respond appropriately. In addition, his ability to report on past events may be distorted by the high risk of confabulation. When a person has dementia, his memory function will attempt to fill in gaps to enable him to respond to questions or to report on past events. While the story may sound logical, it will not be based on fact or accurate memory. The speaker will believe the story to be true, but is not. In essence, for a person such as Mr. Brockman, dementia will render long-term memory inaccessible and defective. Even if he can remember past events, he cannot accurately relate them to the question that he is being asked in the present or assimilate the information to report it accurately. If he can compose a response at all, it will likely be the product of such confabulation, rather than genuine memory.

For these reasons, I concur with the medical position that Mr. Brockman cannot assist his attorneys in his defense, if criminal charges were to be brought against him.

Sincerely,



James L. Pool, M.D.

Professor of Medicine and Pharmacology
Baylor College of Medicine, Houston, TX

EXHIBIT M

Joseph Jankovic, MD

Parkinson's Disease Center and Movement Disorders Clinic

It is characteristic that a person with dementia, such as Mr. Brockman, will be unable to recall information that is needed to respond accurately when asked questions. As a result of Mr. Brockman's cognitive impairment, he has trouble accessing information and making connections between questions that he is being asked and his recollection of events. It is a characteristic of this dementia that Mr. Brockman may engage in confabulation, in which the brain will attempt to fill in missing information, causing him to sometimes make up stories or provide information about something that has not occurred. Confabulation differs from prevarication or lying. Confabulation is a symptom of cognitive impairment, and is not voluntary. A cognitively impaired person who

engages in confabulation will believe that he is reporting truthfully. A person with Mr. Brockman's cognitive impairment may appear to be engaged in a normal discussion, but any information that he may provide may be partial and not complete or accurate.

In summary, Mr. Brockman's dementia leaves him unable to provide accurate information about past events.

Sincerely,

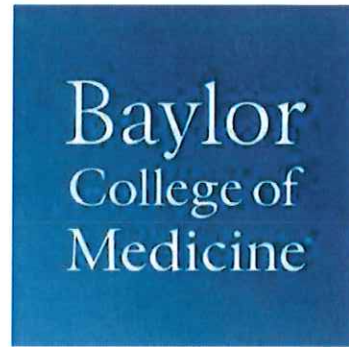
A handwritten signature in black ink, appearing to read "Joseph Jankovic". The signature is fluid and cursive, with the first name "Joseph" and last name "Jankovic" clearly distinguishable.

Joseph Jankovic, MD

EXHIBIT N

Melissa Yu M.D.,FAAN

**Alzheimer's Disease & Memory Disorders
Center**
7200 Cambridge St, 9th Floor, Ste 9B
Houston, TX 77030
Phone: (713) 798-2273
Fax: (713) 798-7434
www.bcm.edu



January 21, 2020

Kathryn Keneally
Jones Day
250 Vesey Street
New York, NY 10281

Re: Robert T. Brockman

Dear Ms. Keneally:

At your request, I am providing this letter to respond to questions that you raised concerning my examination of Robert Brockman. I understand that you will provide a copy of my report dated February 20, 2019, and this letter to the U.S. Department of Justice.

You asked specifically about the comments made by Mr. Brockman's son that Mr. Brockman experiences fluctuations in decision-making ability. Patients with most forms of dementia experience anosognosia, which means that they lose insight into the cognitive limitations of their disease. Individuals with dementia may perceive themselves as functioning normally, even well. Individuals with dementia, who have good social instincts and expansive vocabulary may appear to function well on a surface level, and will retain "social niceties" despite sometimes-significant levels of cognitive impairment. Similarly, individuals who have been in business or professionally active for a long time may be able to speak on business issues in a way that appears functional, but will face difficulties when pressed for decisions or specifics. Patients with Lewy body dementia will often experience day-to-day and even hour-to-hour fluctuations in their ability to function.

Dementia of any kind is more than simple memory loss. The impact of dementia includes visual spatial function, language, memory, and executive function – in essence, all aspects of thought and cognitive function. As an example, if a requested action requires three steps, a person with dementia will have difficulty paying attention to the request, remembering each step, and resisting distraction while completing the action.

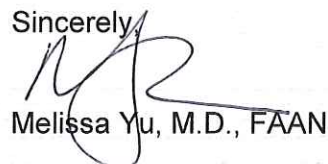
Sincerely,

Melissa Yu, M.D., FAAN

EXHIBIT O



Michele K. York, PhD, ABPP-CN
 Board Certified Clinical Neuropsychologist
 Associate Professor
 Department of Neurology

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Robert Brockman
 Date of Birth (Age): [REDACTED] (78 yr.)
 Date(s) of Evaluation: 12/03/2019
 Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor
 Referred by: James Pool, MD
 Referral Question: Independent Neuropsychological Examination

BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male with a two to three-year history of short-term memory loss. The neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning was conducted by request by Kathy Keneally, Partner, Jones Day (New York). The following information was obtained during an interview with Mr. Brockman and his wife, his previous clinical neuropsychological evaluation conducted on 03/01/2019 and limited review of medical records.

Declarations: A forensic evaluation differs from a clinical evaluation in that there is no traditional doctor-patient relationship between the psychologist and the person being evaluated. The purpose of the evaluation is to assist Ms. Keneally in defense for Mr. Brockman's legal tax case; therefore, establishing a treatment relationship would create a potential conflict between the psychologist's role as an objective evaluator versus an advocate for the patient. Consequently, it is important that a retained expert avoid the role of treatment provider. This standard is mandated by the laws of the State of Texas (Texas Administrative Code) as well as the Code of Ethics of the American Psychological Association (2010), and it represents the official position of the National Academy of Neuropsychology (Bush, 2005).

Dr. York was retained for a neuropsychological evaluation by Kathy Keneally of Jones Day. As explained above, she is excluded from providing any direct treatment to Mr. Brockman. Consequently, Dr. York's role was necessarily restricted to that of a forensic consultant rather than a treating doctor in this context. Mr. Brockman was informed of these conditions and consented to the evaluation and to his ability to understand these limitations.

Opinions reached in this report are based on direct interview and results of my neuropsychological evaluation and a review of his provided medical records to clarify the timeline of her medical procedures and hospitalizations. These opinions are based on current neuropsychological assessment techniques and research. Opinions are based upon reasonable neuropsychological probability and are subject to modification based on provision of additional information. The data from this evaluation is contained in Dr. York's confidential files.

Previous Neuropsychological Assessment: Mr. Brockman underwent a clinical neuropsychological evaluation with Dr. York on 03/01/2019. His general intellectual functioning (WAIS-IV FSIQ=87) fell within the low average range, which was a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuoconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found

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within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming. This pattern of neuropsychological performance indicated a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produced moderate familial distress. He demonstrated movements that were consistent with a parkinsonism disorder. These abnormal movements taken together with his current diagnosis of dementia, and REM Behavior Disorder, his pattern of cognitive impairments was reported as consistent with Dementia with Lewy Bodies (DLB).

Current Concerns and General Condition: Mr. Brockman and his spouse participated in the clinical interview. Mr. Brockman reported that his balance has declined over the past year. He has been using a balance board at the Houstonian but is not making any progress. He denied any falls.

On direct inquiry, he reported that his tax issues are about a small company that he sold to a family trust in 1981. He noted that the government is “mad at him” but “they don’t say why,” and they want to “confiscate the trust.” He said the government is information gathering and talking to people he used to work with. He is concerned that the company will be “ruined” and this will affect the people who work there. He noted that he is starting to think about who will run the company. He reported that he thinks he can continue to be the chairman.

Mrs. Brockman described that her husband’s cognition fluctuates on a daily basis from minute to minute. She described that he has “blank times” that he appears more confused. His wife noted that he was having difficulties at work and she had to help him type all of his employee performance reviews. She reported that he has increased initiation problems. He reported that he does not go into the office as much as he did in March 2019. He noted that it takes him longer to process information at work. His wife described that he sits at work for many, but he does not accomplish his tasks described. His short-term memory has continued to decline, and he is repeating himself more often. He is unable to recall details from his daily activities even later in the day. His procedural memory has also declined as he has forgotten how to tie a tie or to use a remote control for their television. She noted that he does not recall the code to unlock his telephone. He has difficulties completing tasks. His wife drives him to the office. She noted that he has declines in his spelling ability particularly while typing. He is unable to multi-task.

Emotional Functioning: Mr. Brockman reported that he began taking Wellbutrin which has improved his mood, but he continues to feel “slightly depressed.” He noted that his diagnosis brings him “more down than before.” He noted that he has realized that “all of sudden I am old.” He denied heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he is harder to wake up. He is more violently acting out his dreams and has been kicking. He takes trazadone to aid his sleep. He has decreased appetite and has lost 20lbs over the past several months. His wife reported that he began to act out his dreams at least three years ago. He reported that he has floaters in his visual fields. He continued to deny visual hallucinations. It is noted that he had a previous visual illusion described below and a visual hallucination of a bug on the testing room floor that was not present to either the examiner or his wife during his evaluation in March 2019.

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Previous Cognitive Complaints: Mr. Brockman reported declines in his short-term memory over the past 2 to 3 years. He and his wife reported that he is repeating himself, losing possessions, losing his train of thought and is more tangential. He forgets names of new individual and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and has hit curbs while driving and parking. He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking.

Medical History: Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, hypercholesterolemia, glaucoma (mild), erectile dysfunction, tremor, micrographia, and back problems. He has plantar fasciitis, which reduces his exercise ability. He reported that he was hospitalized for a prostate infection and pericarditis four years ago. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa in February 2019. His wife noted a mild motor improvement when he first started on the medication, but when the medication was increased, he had increasing clumsiness. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines.

Medications: Wellbutrin 100mg tid, trazodone 50mg at night, Synthroid .75mg, Eliquis 2.5mg bid, aspirin, carbidopa/levodopa 25/100mg 2 tablets tid, stool softener, Exelon 2 patches. He noted that he also takes a regimen of vitamins and supplements.

Social History: Mr. Brockman has been married for 50 years, and they have one son. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

REVIEW OF LIMITED MEDICAL RECORDS

Dr. Joseph Jankovic Evaluation: Mr. Brockman was evaluated by Dr. Joseph Jankovic on March 13, 2019 for his movement disorder. He was diagnosed with postural instability gait disorder subtype (PIGD) of parkinsonism. Dr. Jankovic noted that because Mr. Brockman denied hallucinations and cognitive fluctuations that he does not meet criteria for DLB; however, he acknowledged that he meets criteria for dementia. Mr. Brockman noted that he was worse physically and mentally despite taking levodopa, with a “zombie-like effect” as described by his wife.

Dr. Melissa Yu Evaluation: Mr. Brockman was evaluated by Dr. Melissa Yu on March 20, 2019 for his memory loss. Memory loss was dated to November 2017 in a medical chart note. Dr. Yu medical note stated that a DATSCAN was performed showing significant loss of dopaminergic signal, and he was started on Sinemet and the Exelon patch on 3/13/2019. Anosmia was reported for 10 years. Memory, word finding, and slowed processing speed were reported by his wife and son. His son noted that his father’s cognitive ability fluctuates, with episodes of “blankness” associated with less interaction alternating with improved cognition. His son also noted cognitive fluctuations in his father’s decision making abilities with good and bad days. It was noted that his son has him

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practice clock drawing to test his functioning. Dr. Yu's differential diagnoses included Dementia with Lewy Bodies or Parkinson's Disease Dementia. It was noted that the time course and fluctuations in cognition were more suggestive of DLB.

BEHAVIORAL OBSERVATIONS: Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his spouse who participated in the clinical interview. General appearance was neat and clean. The patient exhibited slowed motor behavior and gait and a mild tremor which was notable on drawings but did not interfere with his performances. He evidenced slowed response latencies. His mood was pleasant, but his affect was flat. Eye movements were normal. Vision (with corrective lenses) and hearing were adequate for the testing session. Conversational speech was coherent but was tangential in conversational speech. There was no evidence of paraphasias. His cognition tended to fluctuate throughout the testing session. He appeared to be confused at times even in the middle of tasks that he originally was completing accurately. He showed mildly decreased ability to follow directions, and he occasionally needed repetition of directions and lost place during set task. He exhibited cooperative test-taking behavior. His attitude towards the examiner was appropriate and friendly. He tended to minimize his cognitive impairments. He passed several embedded and stand-alone measures of performance validity; therefore, the following results are thought to be an accurate estimation of his current cognitive abilities.

MEASURES ADMINISTERED

Montréal Cognitive Assessment (MoCA); Caregiver Neuropsychiatric Inventory (NPI-Q); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVLTR); Neuropsychological Assessment Battery (NAB subtests: Daily Living Memory-Delayed, Daily Living Memory-Immediate, Daily Living Memory-Recognition, Naming, Numbers and Letters, and Visual Discrimination); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Verbal Fluency Test; Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Arithmetic, Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition); Wide Range Achievement Test (WRAT-4 subtest: Math Computation); Wisconsin Card Sorting Test (WCST); Instrumental Activities of Daily Living Scale (IADLS); Lawton and Brody Physical Self-Maintenance Scale (PSMS). Clinical Interview with patient and his spouse.

Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) measure as he was unable to comprehend task instructions and maintain task set independently. Informant questionnaires were completed by the patient's spouse.

NEUROPSYCHOLOGICAL FINDINGS

The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).

Mental Status: Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is moderately below expectation. He was fully oriented (6/6). He demonstrated difficulties with set shifting,

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visuospatial construction, sustained attention, repeating one sentence, serial subtractions, and with verbal fluency. He did not recall any words (0/5) and was not aided by category cueing. He was aided by multiple choice cueing for 4/5 words.

Intellectual: Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from low average to high average yielding a pro-rated Full Scale IQ estimate of 96, which is in the average range.

Attention/Concentration: Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was average with 6 digits forward, 4 digits backward, and 5 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was low average. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was deficient with 0 errors. Written math computation revealed a 5.6 grade equivalent. It is noted that he was unable to perform simple addition, multiplication and division arithmetic problems (e.g., $3 \times 4 = 7$, $14/3$).

Executive: Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was borderline impaired. His abstract verbal reasoning was average. Working memory to perform mental arithmetic was average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued as he was unable to comprehend the task instructions and he was unable to set shift independently. Performance on a novel task of problem-solving and hypothesis testing fell in the low average range (11-16th percentile) with 1 correct category achieved by the end of the task. He made numerous "Other" responses that did not match to any of the 3 possible correct categories. He lost set one time and had to be reminded of the instructions after each card so that he would not match to the wrong set of cards. His performance fluctuated during this task.

Memory: Recall of culturally-based general knowledge was high average. Immediate recall of verbally presented contextual material was average (SS=8). Delayed recall of the stories was low average (SS=7). Retention of initially learned material was 50.0%. Recognition memory was average (16/23). Incremental learning for a semantically-categorized word list across 3 trials was deficient (1, 4, and 4 words per trial), and delayed recall was in the deficient range with 25.0% retention which falls within the deficient range. On recognition memory assessment, 10/12 target words were correctly identified, 3 false positive errors were committed, with discrimination accuracy in the borderline impaired range.

Immediate recall of basic geometric figures was borderline impaired (SS=4). Delayed recall of the designs was deficient (SS=2). Retention of the initially learned material was 0.0%. Recognition memory was average (2/7).

Language: Lexical fluency was borderline impaired with between 5 to 8 words per trial. Semantic fluency was low average with 14 exemplars generated. Confrontation naming of pictured objects was average (NAB Form 1; 29/31). He made an error of transitive limb praxis which was improved with imitation

Visual-Perceptual: His drawing of a complex geometric design scored in the low average range. He demonstrated a mild tremor but it did not interfere with his drawing ability. He maintained the overall gestalt but he distorted or omitted several of the internal details. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was within normal limits to command (CDT=10/10) and impaired

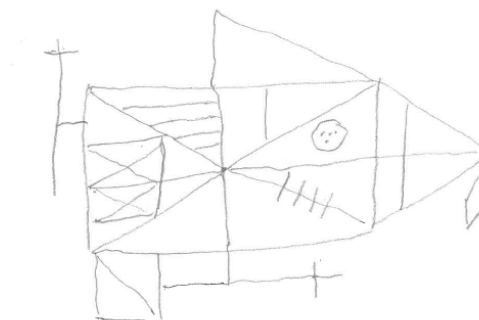
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when copying a model (CDT=8/10). He drew the clock face and began placing the numbers accurately but then the numbers ended in the middle of the clock face. He placed the hands accurately to where he drew the numbers.

Examples of visuospatial performances highlighting Mr. Brockman's fluctuating cognitive functioning.**Rey Complex Figure Test – Copy of a Design****03/01/2019****12/03/2019****Clock Drawing****03/01/2019****12/03/2019**

Mood / Personality: On a self-report measure of anxiety, his responses fell in the minimal range (GAD-7=4/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of probable depression (GDS=19): presently unsatisfied with life, terminating activities and/or lack of interest, lack of hope regarding the future, ruminating thoughts, feeling as though something negative is going to occur, unhappiness, helplessness, preferring to stay home, worry about the future, declines in memory, downhearted and blue, lack of excitement for life, difficulty beginning new projects, poor energy, hopelessness, difficulties with concentration, difficulties with decision making, and general declines in thinking skills.

Activities of Daily Living: His spouse served as the informant completing a questionnaire regarding the patient's ability to complete basic and instrumental activities of daily living. Mr. Brockman reportedly has difficulties with self-care ADLs (PSMS=7/30). It was noted that he is constipated and goes to the restroom every half hour; he eats, dresses, grooms, and bathes very slowly. He requires assistance with ambulation. He requires assistance with instrumental activities of daily living (IADLs=14/31) including telephone use, shopping, food preparation,

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transportation, and finances. His wife noted that he seldom uses his phone. He fluctuates in his ability to handle money even with day-to-day expenses. She has to remind him to take his medications, and if she does not then she notices that he has forgotten to take doses.

Neurobehavioral: The patient's spouse completed an inventory assessing for the presence of neurobehavioral symptoms commonly associated with dementia, reportedly observing mild problems with disinhibition and motor disturbance and moderate problems with agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite (NPI-Q severity=12; distress=25) which produce an overall moderate to extreme level of familial distress.

SUMMARY AND IMPRESSION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male who underwent an independent neuropsychological evaluation as a component of a forensic evaluation. The factual matters stated in this report are, as far as I know, true, and the opinions in the report are genuinely held by me and the report contains reference to all matters I consider significant.

It is this examiner's opinion based on the testing conducted and behavioral observations that Mr. Brockman was putting forth full effort and was not exaggerating or embellishing the nature and extent of his cognitive impairment. It is noted that neuropsychological tests were chosen to best assess Mr. Brockman's cognitive abilities. The testing environment was optimal and the following results are considered a valid estimate of his current neuropsychological and emotional status.

Mr. Brockman currently operates in the average range of general intellectual functioning (WAIS-IV FSIQ=96), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30 (total), 6/6 (orientation), and 0/5 (short-term recall), which is moderately impaired. Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 14/30, and his wife indicated a significant decline in his functional ability.

Self-report of depression was elevated (GDS=19), but he did not endorse elevated levels of anxiety (GAD-7=4). The NPI-Q completed by his wife (severity=12; distress=25) indicated problems with disinhibition, motor disturbance, agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite for an overall moderate to extreme level of familial distress.

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of oral and written processing speed, executive functions (including working memory, problem solving, inhibition, set shifting, and verbal fluency), learning and recall of a word list, learning and recall of visual material, and basic visuospatial functioning. His intellectual functioning subtest scores remained within the broadly average range (low average to high average). It is noted that his verbal memory was aided by context with average learning of a story, but he only retained 50% of the material he originally learned after a brief delay (low average). His written arithmetic performance was a 5.6 grade equivalent with difficulties noted in performing basic addition, multiplication and division problems. His basic attention and language (naming and semantic fluency) performances were average.

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Comparison with prior results obtained on 03/01/2019 revealed the following pattern of interim changes:

Declines were found in the areas of:

- Verbal fluency (low average to borderline impaired)
- Graphomotor sequencing (borderline impaired to deficient)
- Learning of a word list (borderline impaired to deficient)
- Decreased functional abilities

Improvements were found in the areas of:

- Sequencing of digits (deficient to average)
- Learning and recall of contextual information (deficient to average and low average with only 50% retention)
- Clock drawing (impairments remain)
- Visuospatial construction of a complex figure

It is noted that Mr. Brockman's cognition fluctuated significantly throughout the evaluation. He demonstrated improvements on a few measures; however, during several tasks, he became more confused and demonstrated a blank stare expression. These fluctuations were more apparent during this evaluation as compared to his previous evaluation in March 2019. Mr. Brockman's pattern of neuropsychological performance indicates a dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. Mr. Brockman's current cognitive pattern and his parkinsonism, taken together with his dementia at the time of diagnosis of his movement disorder, cognitive fluctuations, and REM Behavior Disorder are consistent with a diagnosis of Dementia with Lewy Bodies (DLB). Visual hallucinations are a hallmark of DLB; however, up to 30% of patients with DLB do not demonstrate visual hallucinations particularly at the early stages of the disorder. Mr. Brockman reported a previous visual illusion and a mild visual hallucination was present during neuropsychological testing in March 2019, which further supports this diagnosis. His dementia falls under the diagnostic category of Lewy Body Dementias.

Based on the current cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it is my opinion that Mr. Brockman is unable to participate and aid in his own defense. He is unable to recall and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that will allow him to make comparisons and weigh his options.



Michele K. York, PhD, ABPP-CN

Board Certified Clinical Neuropsychologist

TX License #31159

EXHIBIT P

Patient Information

Name: ROBERT THERON BROCKMAN
Medical Record Number: 0300937767
Sex Code: M
BirthDate: [REDACTED]

Exam Information

Accession Number: 201902140001
Modality: NM
Body Part: HEAD
Description: NM DATSCAN BRAIN SPECT
Performed Date: 2/14/2019 11:22:21
Patient History: G20

Final Report

Dopamine Transporter Imaging (DaTscan)
Brain Imaging, tomographic (SPECT)

Reason for exam: G20: Parkinson's disease

Report: The patient received Lugol's solution 10 drops in 30 mL of water for thyroid blockade 30 minutes prior to injection of the radiopharmaceutical. I-123 ioflupane 4.5 mCi was administered intravenously. Tomographic images of the head were obtained at approximately 4 hours post administration of the radiopharmaceutical.

Tracer activity is visually absent in the bilateral putamina. Tracer accumulation is markedly decreased in the caudate nuclei relative to background tracer activity. Decrease of tracer is slightly greater in the right caudate nucleus compared to the left.

Impression:

Severe loss of dopaminergic neuronal function in the bilateral dorsal striata with loss greater on the right compared to the left.

Semi-quantitative analysis using the DaTQUANT program supports the above interpretation. The DaTQUANT report is included with the images on PACS.

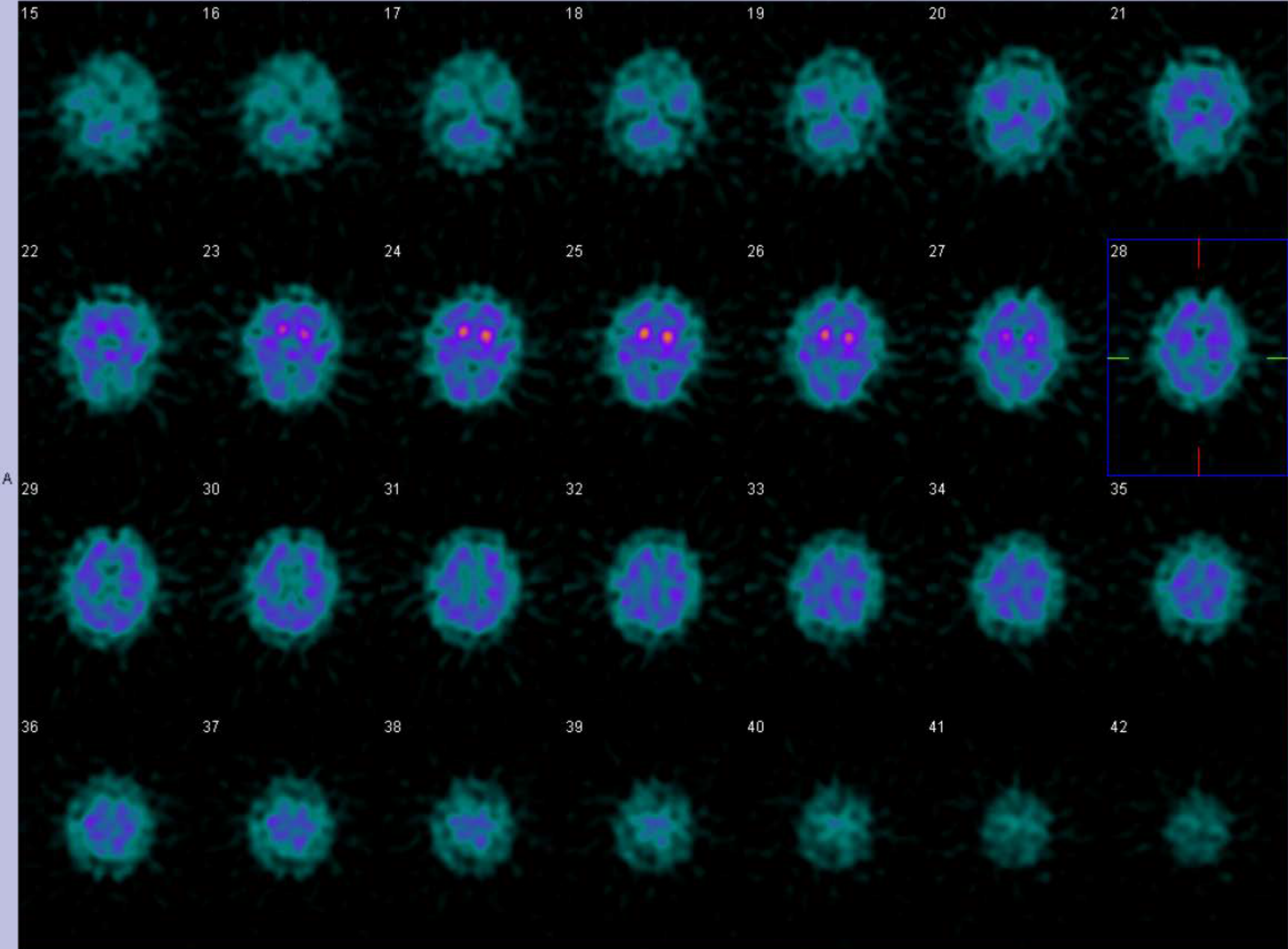
Signed by: Dr. Julie Wendt, M.D. on 2/15/2019 7:22 AM

Principal Interpreter

Name: Provider JWENDT
Provider ID: JWENDT

Row A - DATSCAN BRAIN [Recon - NoAC]

Transverse



R
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Anterior
Posterior
L
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f
t

Bottom
to
Top

Patient Name: BROCKMAN, ROBERT THERON

DOB: [REDACTED]

Patient ID: 0300937767

Case 2:19-cv-00093-DWM Document 1-1 Filed 02/18/20 Page 1 of 1

Sex: M

Study Name: BRAIN DATSCAN

Study Date: 2/14/2019

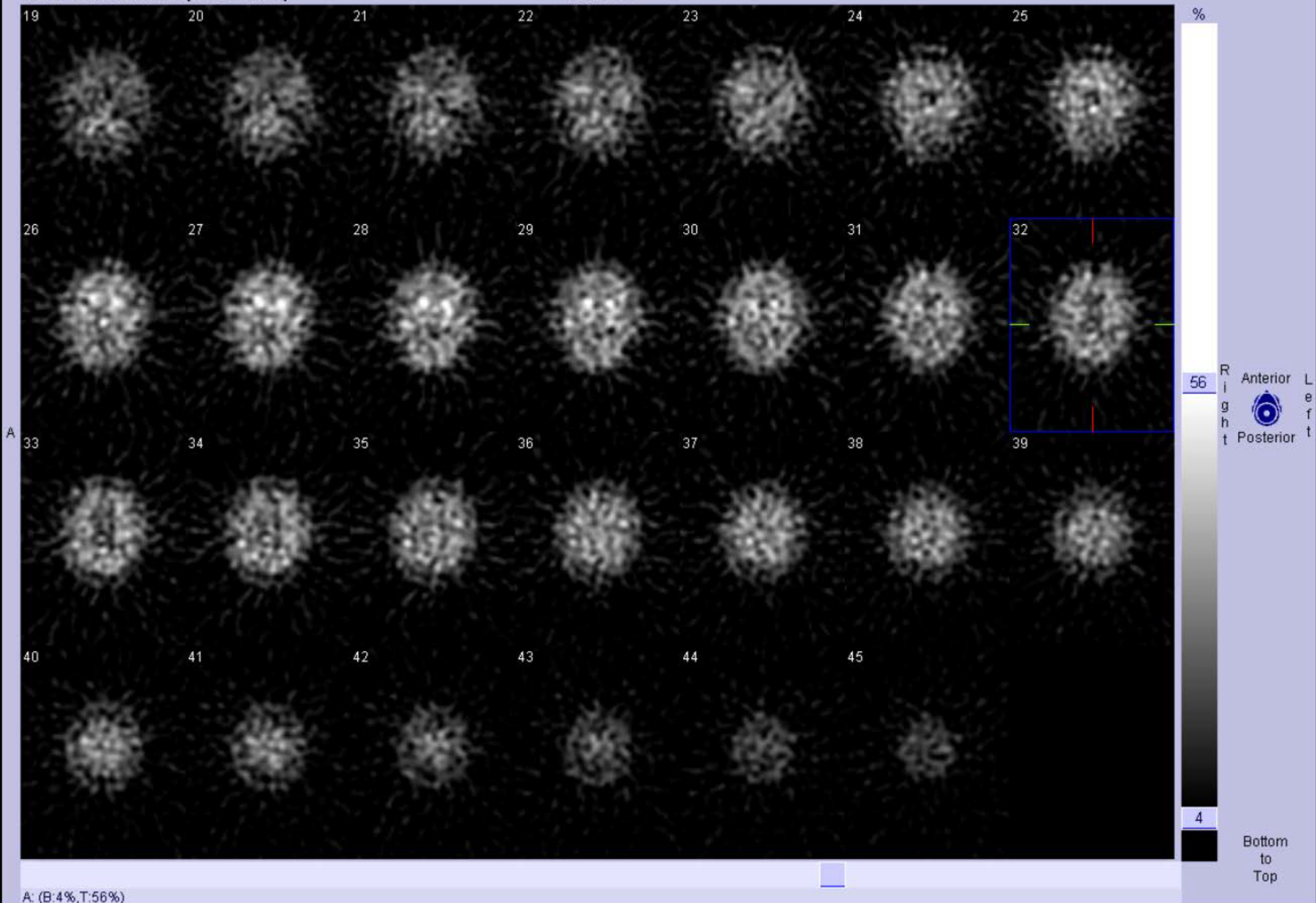
Radiopharmaceutical 1: 0.0 MBq (0.00 mCi)

Study Time: 11:22:21 AM

Baylor Clinic AV

Row A - DATSCAN BRAIN [Recon - NoAC]

Transverse



Case Case ID: 200000937, Data File: 200000937-1, File 4-2n Filed 12/21/18 TX SD Page 10 of 108

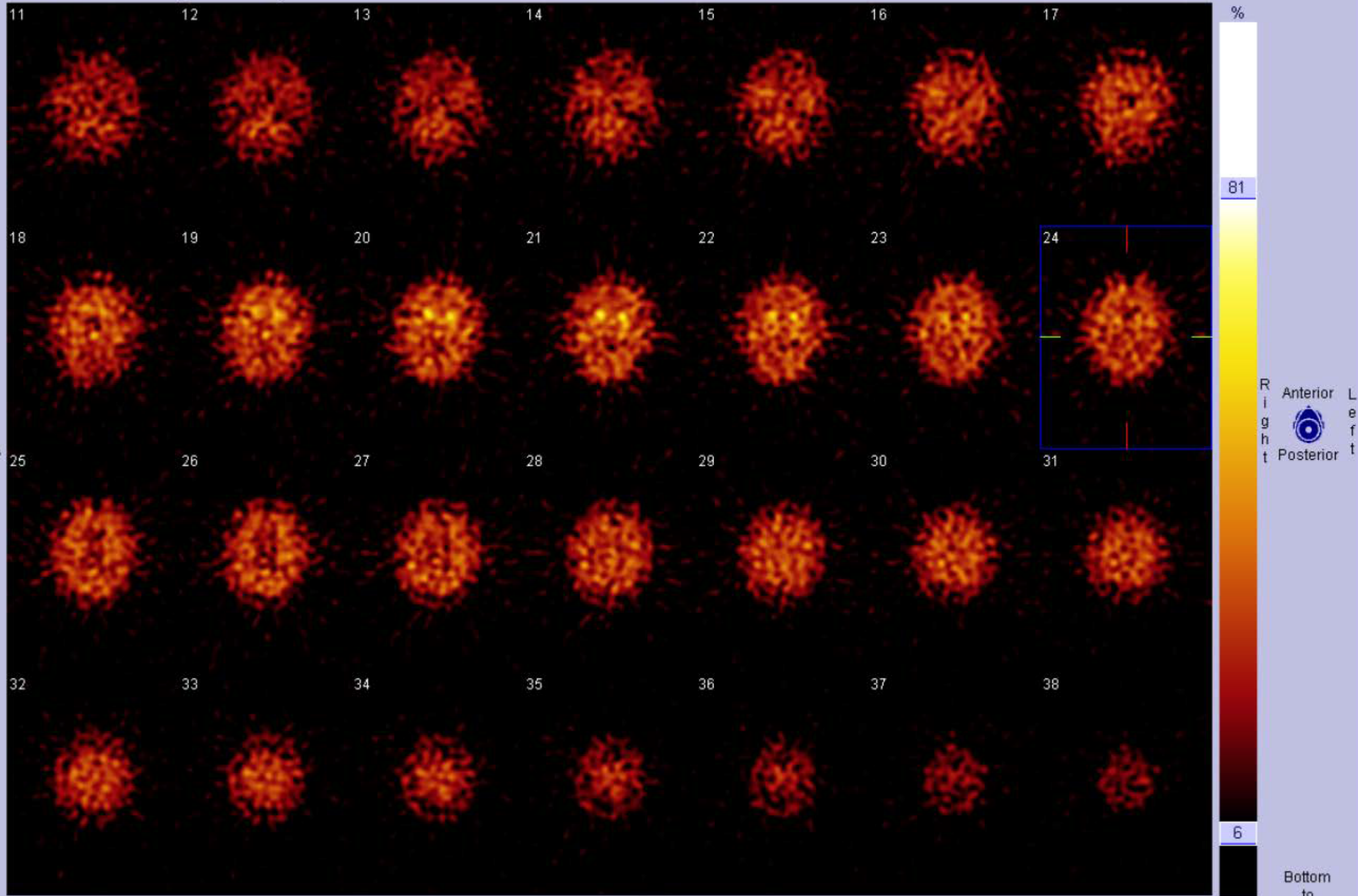
Sex: M

Study Time: 11:22:21 AM

Baylor Clinic AV

Row A - DATSCAN BRAIN [Recon - NoAC]

Transverse



A: (B:6%,T:81%)

Patient Name : BROCKMAN ROBERT THERON

Patient ID : 0300937767

Exam Description : Tomo_Transaxials

Exam Date : Feb 14, 2019

Referring Physician :

Reading Physician : Julia Wendt

Data : IRNC REGISTERED

Age (Years) : 77

Camera : IP2

Collimator Name : LEHR

Collimator Type : Parallel

Counts (kCounts) : 2074.1

Dose (mCi) : 4.5

Gender : Male

Radiopharmaceutical : DaTscan

Reconstruction Type : OSEM

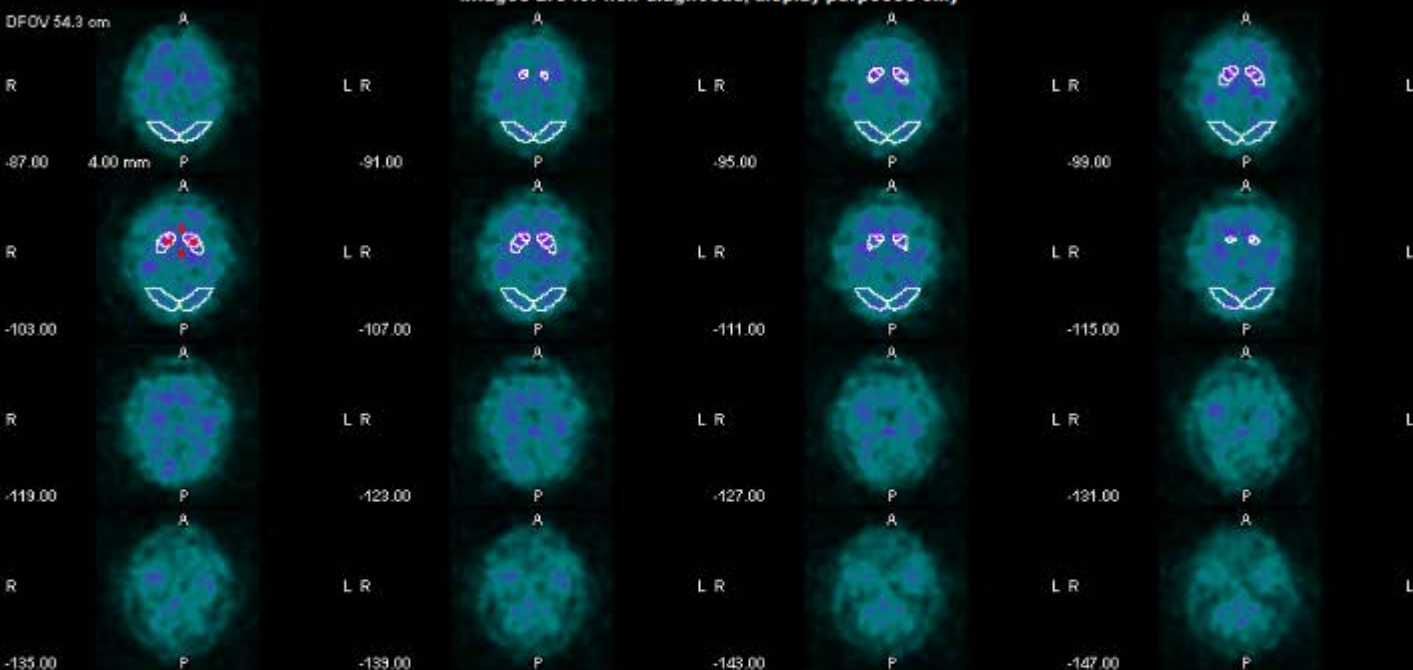
Corrections : No Correction

Normal DB : GE OSEM NC NDB

GE normals database for OSEM with no correction

Manually Modified

Images are for non-diagnostic, display purposes only



[Non-Rigid Registration : Automatic Processing]

| | Measured | Mean (± 1 SD) | Deviation | Z-Score |
|--------------------|----------|----------------------|-----------|---------|
| Striatum Right SBR | +0.46 | +1.79 (± 0.23) | -74% | -3.98 |
| Striatum Left SBR | +0.49 | +1.73 (± 0.35) | -72% | -3.50 |
| Putamen Right SBR | +0.36 | +1.70 (± 0.33) | -79% | -4.09 |
| Putamen Left SBR | +0.43 | +1.63 (± 0.35) | -74% | -3.47 |
| Caudatus Right SBR | +0.68 | +2.01 (± 0.40) | -66% | -3.35 |
| Caudatus Left SBR | +0.62 | +1.94 (± 0.42) | -68% | -3.13 |
| Striatum Asymmetry | +0.02 | +0.03 (± 0.02) | -26% | -0.37 |
| Putamen Asymmetry | +0.05 | +0.03 (± 0.03) | +36% | +0.47 |
| Caudatus Asymmetry | +0.03 | +0.05 (± 0.04) | -24% | -0.30 |

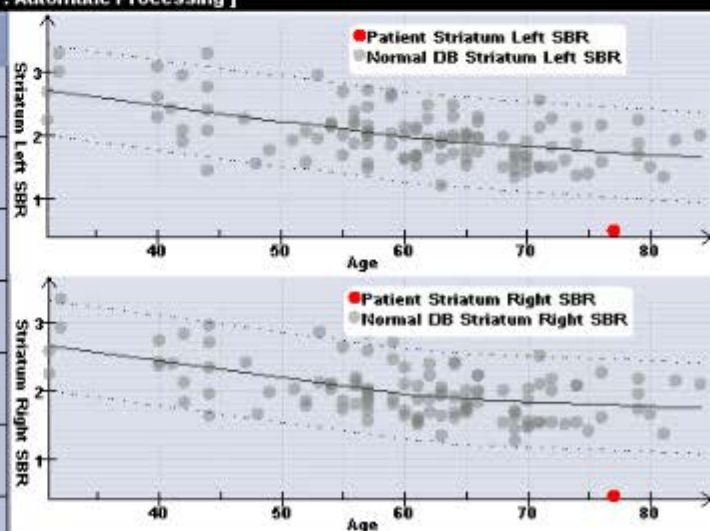
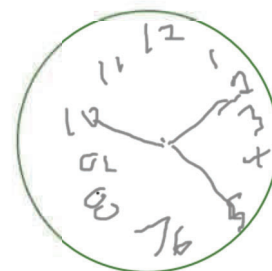


EXHIBIT Q

| SCORE | TODAY |
|-----------------|-------|
| 3-WORD MEMORY | 2 |
| ORIENTATION | 4 |
| SEQUENCE MEMORY | 4 |
| TIME | 3 |
| TOTAL SCORE | 13 |



James L. Pool, MD



Disclaimer: This test has high levels of sensitivity, specificity and reliability, but does not replace comprehensive neuropsychological and medical evaluation. Our recommendations are based on current research and extensive clinical experience with this population. The CogniSense™ tool has been validated in English speaking adults ages 60 to 92 in a community-based primary care setting.

References:

- Clionsky, M and Clionsky E, "Development and Validation of the Memory Orientation Screening Test," American Journal of Alzheimer's Disease & Other Dementias, 2010, 25 (8), 650-656
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EXHIBIT R



Michele K. York, PhD, ABPP-CN
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 Professor
 Department of Neurology

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Robert Brockman
 Date of Birth (Age): [REDACTED] (79 yr.)
 Date(s) of Evaluation: 10/07/2020
 Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor
 Referred by: James Pool, MD/Kathy Keneally, Jones Day
 Referral Question: Independent Neuropsychological Examination

BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 79 year-old, right-hand dominant, Caucasian male with a three to four-year history of cognitive and behavioral decline. The neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning was conducted by request by Kathy Keneally, Partner, Jones Day (New York) and Dr. James Pool. The following information was obtained during an interview with Mr. Brockman and his son, Robert, his previous clinical neuropsychological evaluation conducted on 03/01/2019 and his previous forensic evaluation conducted on 2019 and limited review of medical records.

Declarations: A forensic evaluation differs from a clinical evaluation in that there is no traditional doctor-patient relationship between the psychologist and the person being evaluated. The purpose of the evaluation is to assist Ms. Keneally in defense for Mr. Brockman's legal tax case; therefore, establishing a treatment relationship would create a potential conflict between the psychologist's role as an objective evaluator versus an advocate for the patient. Consequently, it is important that a retained expert avoid the role of treatment provider. This standard is mandate by the laws of the State of Texas (Texas Administrative code) as well as the Code of Ethics of the American Psychological Association (2010), and it represents the official position of the National Academy of Neuropsychology (Bush, 2005).

Dr. York was retained for a neuropsychological evaluation by Kathy Keneally of Jones Day. As explained above, she is excluded from providing any direct treatment to Mr. Brockman. Consequently, Dr. York's role was necessarily restricted to that of a forensic consultant rather than a treating doctor in this context. Mr. Brockman was informed of these conditions and consented to the evaluation and to his ability to understand these limitations.

Opinions reached in this report are based on direct interview and results of my neuropsychological evaluation including an interview with Mr. Brockman and his son, Robert, and a review of his provided medical records to clarify the timeline of his medical procedures and hospitalizations. These opinions are based on current neuropsychological assessment techniques and research. Opinions are based upon reasonable neuropsychological probability and are subject to modification based on provision of additional information. The data from this evaluation is contained in Dr. York's confidential files.

Previous Neuropsychological Assessments: Mr. Brockman underwent a clinical neuropsychological evaluation with Dr. York on 03/01/2019. In 2019, his general intellectual functioning (WAIS-IV FSIQ=87) fell within the low average range, which was a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of

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sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuoconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming. This pattern of neuropsychological performance indicated a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produced moderate familial distress. He demonstrated movements that were consistent with a parkinsonism disorder. These abnormal movements taken together with his current diagnosis of dementia, and REM Behavior Disorder, his pattern of cognitive impairments was reported as consistent with Dementia with Lewy Bodies (DLB).

Mr. Brockman underwent a second neuropsychological evaluation on 12/03/2019. This evaluation revealed average general intellectual functioning (WAIS-IV FSIQ=96), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30, which is a moderately impaired performance. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of oral and written processing speed, executive functions (including working memory, problem solving, inhibition, set shifting, and verbal fluency), learning and recall of a word list, learning and recall of visual material, and basic visuospatial functioning. His written arithmetic performance was a 5.6 grade equivalent with difficulties noted in performing basic addition, multiplication and division problems. His basic attention and language (naming and semantic fluency) performances were average. Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 14/30, and his wife indicated a significant decline in his functional ability.

Comparison with prior results obtained on 03/01/2019 revealed declines on measures of verbal fluency (low average to borderline impaired), graphomotor sequencing (borderline impaired to deficient), learning of a word list (borderline impaired to deficient), and decreased functional abilities. He demonstrated improvements in the areas of sequencing of digits (deficient to average), learning and recall of contextual information (deficient to average and low average with only 50% retention), and visuospatial construction of a complex figure, suggesting cognitive fluctuations. Confusion and a blank stare expression was noted during the evaluation.

Self-report of depression was elevated (GDS=19), but he did not endorse elevated levels of anxiety (GAD-7=4). The NPI-Q completed by his wife (severity=12; distress=25) indicated problems with disinhibition, motor disturbance, agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite for an overall moderate to extreme level of familial distress.

Mr. Brockman's pattern of neuropsychological performance indicated dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. His dementia taken together with his parkinsonism, cognitive fluctuations, and REM Behavior Disorder remained consistent with a diagnosis of a Lewy Body Dementia (Dementia with Lewy Body or Parkinson's Disease Dementia). Based on his cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it was opined that Mr. Brockman was unable to participate and aid in his own defense, and he was unable to recall

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and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that would allow him to make comparisons and weigh his options.

Current Concerns and General Condition: Mr. Brockman and his son, Robert, participated in the clinical interview. Mr. Brockman reported that his right hand tremor has progressed. He reported overall muscle weakness in his legs and an issue with his rotator cuff from tension and lifting weights. He noted that he discontinued taking his testosterone on his own. He is taking levodopa but he was unsure of his medication regimen as he noted his wife manages his medication box. He noted that he is continuing to use his balance board, but he tends to fall backwards and catch himself. He has not had any actual falls in which he has injured himself.

Mr. Brockman and his son described that his cognition has declined since December 2019 when he was last evaluated. He noted, in particular, his short-term memory and his working memory have declined and his processing speed is slower. He noted declines in his decision making abilities. He repeats himself and asks the same question again without insight. He forgot the passcode to unlock his phone, and he lost his phone. He forgets names of familiar individuals. He is disoriented to month and day of the week, which his family has noted when he is attempting to complete forms. He stopped driving 1 ½ years ago. He has increased word finding difficulties and attempts to google to find the word for which he is searching.

Emotional Functioning: Mr. Brockman reported that his mood is “not good.” He described that business has been difficult and his “morale is not what it used to be.” He is more apathetic. Due to COVID-19, his activities have been limited. He continues to work from home. He noted that the company did not have to lay anyone off and they have transitioned to working remotely. He is continuing to take Wellbutrin which has stabilized his mood. He denied heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he wakes up more often at 3am and is unable to get back to sleep due to anxiety. He relies on a sleeping aid (trazadone) a couple of times per week. He stated that he was yelling out in his sleep more often. He has decreased appetite with weight loss of 11lbs. He craves ice cream. He denied well-formed visual hallucinations, but he described that he will see things that look like bugs on a shirt, the floor, or a table and wait to see if it moves.

During a telephone call on 11/10/2020, Mr. Brockman’s son, Robbie, described a delusional incident that occurred on 10/17/2020 and 10/18/2020 with his father. Robbie reported that he went to visit his father on Saturday night for a couple of hours. He left the house around 7pm. His father woke up at 5am on Sunday and heard an external door opening and closing and his son’s car driving away. Mr. Brockman went to his office and reported that his computer was on and was unlocked. He stated that the computer was open to pages from the dark web and suicidal information. Mr. Brockman took pictures of the screens, which were actually Yahoo answer pages not related to the dark web or suicide. He was convinced that his son had returned to the house during the night and had broken into his computer. Once he was told otherwise, he thought someone else had entered the house and broken into his computer. The alarm had not been tampered with and there was no one on video entering or exiting the residence during the evening. The family had the computer hard drive analyzed by a third party and did not find any evidence of any tampering or that anyone had visited inappropriate websites. During this time, Mr. Brockman became overly concerned with when he would get his computer back asking numerous times per day.

Previous Cognitive Complaints: Mr. Brockman reported declines in his short-term memory over the past 3 to 4 years. Previously, he and his family reported that he repeats himself, loses possessions, loses his train of thought

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and is tangential. He forgets names of new individuals and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and hits curbs while driving and parking (He stopped driving 1 ½ year ago). He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking. Mrs. Brockman described that her husband's cognition fluctuates on a daily basis from minute to minute. She described that he has "blank times" that he appears more confused. His wife noted that he was having difficulties at work and she had to help him type all of his employee performance reviews. She reported that he has increased initiation problems. He noted that it takes him longer to process information at work. His wife described that he sits at work for many, but he does not accomplish his tasks. His short-term memory has continued to decline, and he is repeating himself more often. He is unable to recall details from his daily activities even later in the day. His procedural memory has also declined as he has forgotten how to tie a tie or to use a remote control for their television. She noted that he does not recall the code to unlock his telephone. He is unable to multi-task.

Medical History: Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, hypercholesterolemia, glaucoma (mild), erectile dysfunction, tremor, micrographia, back problems and increased balance problems. He has plantar fasciitis, which reduces his exercise ability. He reported that he was hospitalized for a prostate infection and pericarditis four years ago. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa in February 2019. His wife noted a mild motor improvement when he first started on the medication, but when the medication was increased, he had increasing clumsiness. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines.

Dr. Joseph Jankovic Evaluation: Mr. Brockman was evaluated by Dr. Joseph Jankovic on March 13, 2019 for his movement disorder. He was diagnosed with postural instability gait disorder subtype (PIGD) of parkinsonism. Dr. Jankovic noted that because Mr. Brockman denied hallucinations and cognitive fluctuations that he does not meet criteria for DLB; however, he acknowledged that he meets criteria for dementia. Mr. Brockman noted that he was worse physically and mentally despite taking levodopa, with a "zombie-like effect" as described by his wife.

Dr. Melissa Yu Evaluation: Mr. Brockman was evaluated by Dr. Melissa Yu on March 20, 2019 for his memory loss. Memory loss was dated to November 2017 in a medical chart note. Dr. Yu medical note stated that a DATSCAN was performed showing significant loss of dopaminergic signal, and he was started on Sinemet and the Exelon patch on 3/13/2019. Anosmia was reported for 10 years. Memory, word finding, and slowed processing speed were reported by his wife and son. His son noted that his father's cognitive ability fluctuates, with episodes of "blankness" associated with less interaction alternating with improved cognition. His son also noted cognitive fluctuations in his father's decision making abilities with good and bad days. It was noted that his son has him practice clock drawing to test his functioning. Dr. Yu's differential diagnoses included Dementia with Lewy Bodies or Parkinson's Disease Dementia. It was noted that the time course and fluctuations in cognition were more suggestive of Dementia with Lewy Bodies.

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Medications: Wellbutrin 100mg tid, trazodone 50mg at night, Synthroid .75mg, Eliquis 2.5mg bid, aspirin, carbidopa/levodopa25/100mg 2 tablets tid, stool softener, Exelon 2 patches. He noted that he also takes a regimen of vitamins and supplements.

Social History: Mr. Brockman has been married for over 50 years, and they have one son, who is reported to have a diagnosis of an Autism Spectrum Disorder. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

Behavioral Observations: Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his son who participated in the clinical interview. General appearance was neat and clean. He exhibited slowed, unsteady gait and slowed motor behavior. He evidenced a mild tremor which was notable on drawings but did not interfere with his performances. His mood was pleasant, and affect was appropriate but somewhat flat. Eye movements were unremarkable. Vision (with corrective lenses) and hearing were adequate for the testing session. His cognition fluctuated throughout the testing session. He appeared to be confused at times even in the middle of tasks that he originally was completing accurately. Conversational speech was coherent, but at times he appeared confused, particularly with following directions, and he was tangential without insight. There was no evidence of paraphasias. He showed moderately decreased ability to follow directions, and he often needed repetition of directions due to confusion. He lost place frequently during set task. He exhibited cooperative test-taking behavior, and his attitude towards the examiner was appropriate and friendly. He lacked insight into the severity of his cognitive impairments. The following results are thought to be an accurate estimation of his current cognitive abilities. He passed embedded measures of performance validity; therefore, the following results are thought to be an accurate estimation of his current cognitive abilities.

MEASURES ADMINISTERED

Montréal Cognitive Assessment (MoCA); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVLT-R); Neuropsychological Assessment Battery (NAB subtest: Naming); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Verbal Fluency Test (SVF version: Animals); Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition). Clinical Interview with patient and his son. Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) measure due to cognitive/behavioral problems.

NEUROPSYCHOLOGICAL FINDINGS

The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).

Mental Status: Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is below expectation. He was incompletely oriented (5/6, missing the date) and short-term recall was 0/5. He

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was aided by category cueing for one word and multiple choice cueing for 3 words. He demonstrated difficulties with set shifting, drawing a cube, and placing the hands on a clock face. These three tasks took him 15 minutes to complete, and he attempted the drawing of the cube twice unsuccessfully. He named 2/3 pictured animals. He also had difficulties with serial subtractions and verbal fluency.

Intellectual: Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from extremely low to average yielding a pro-rated Full Scale IQ estimate of 80 which is in the low average range.

Attention / Concentration: Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was borderline with 5 digits forward, 3 digits backward, and 3 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was extremely low. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was deficient with 1 error.

Executive: Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was deficient. His abstract verbal reasoning was average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued.

Memory: Recall of culturally-based general knowledge was average. Immediate recall of verbally presented contextual material was borderline impaired (SS=5). Delayed recall of the stories was borderline impaired (SS=4). Retention of initially learned material was 33.3%. Recognition memory was high average (20/23). Incremental learning for a semantically-categorized word list across 3 trials was deficient (3, 3, and 6 words per trial), and delayed recall was in the deficient range with 0.0% retention which falls within the deficient range. On recognition memory assessment, 9/12 target words were correctly identified, 5 false positive errors were committed, with discrimination accuracy in the deficient range.

Immediate recall of basic geometric figures was borderline impaired (SS=5). Delayed recall of the designs was deficient (SS=2). Retention of the initially learned material was 0.0%. Recognition memory was borderline impaired (1/7).

Language: Lexical fluency was low average with between 8 to 12 words generated per trial. Semantic fluency was deficient with 9 exemplars generated. Confrontation naming of pictured objects was high average (NAB Form 1; 30/31).

Visual-Perceptual: His drawing of a complex geometric design scored in the deficient range. Time required to copy design was borderline impaired. After 5 minutes of attempting to copy this design, the gestalt was not present, and he reported that he was unable to perform this task. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was impaired to command (CDT=6/10) and impaired when copying a model (CDT=7/10). On command clock on the MoCA, he drew the hands to the 10 and the 11 for "10 after 11," and he attempted to place the hands first prior to writing in the numbers. When later asked to draw a clock, he drew a clock face and the numbers 12, 3 and 5, with 13 tic marks and two hands pointing to the second and third tic mark for "10 after 11." When asked to copy a clock, he omitted the number 10 and wrote the numbers 12-7 in the right half of the clock. He did not maintain the hand size differentiation.

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Motor Functioning: Mr. Brockman is right-hand dominant. On formal examination, buccofacial, transitive, and intransitive classes of praxis were intact.

Mood / Personality: On a self-report measure of anxiety, his responses fell in the mild range (GAD-7=5/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of probable depression (GDS=20): presently unsatisfied with life, terminating activities and/or lack of interest, boredom, lack of hope regarding the future, generally poor spirit/mood, feeling as though something negative is going to occur, unhappiness, helplessness, preferring to stay home, worry about the future, declines in memory, downhearted and blue, worthlessness, lack of excitement for life, difficulty beginning new projects, poor energy, difficulties with concentration, lack of enjoyment first thing in the morning, and general declines in thinking skills.

SUMMARY AND IMPRESSION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male who underwent an independent neuropsychological evaluation as a component of a forensic evaluation. The factual matters stated in this report are, as far as I know, true, and the opinions in the report are genuinely held by me and the report contains reference to all matters I consider significant.

It is this examiner's opinion based on the testing conducted and behavioral observations that Mr. Brockman was putting forth full effort and was not exaggerating or embellishing the nature and extent of his cognitive impairment. It is noted that neuropsychological tests were chosen to best assess Mr. Brockman's cognitive abilities. The testing environment was optimal and the following results are considered a valid estimate of his current neuropsychological and emotional status.

Mr. Brockman currently operates in the low average range of general intellectual functioning (WAIS-IV FSIQ=80), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30 (total), 5/6 (orientation), and 0/5 (short-term recall), which is moderately impaired. Self-report of depression was elevated (GDS=20), and anxiety was mildly elevated (GAD-7=5).

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of basic attention, oral and written processing speed, executive functions (including working memory, problem solving, inhibition, and set shifting), learning and recall of prose material and a word list, learning and recall of visual material, and basic and complex visuospatial functioning. His intellectual functioning subtest scores declined from his last evaluation ranging from the deficient to the average range. He continues to demonstrate average scores on fund of information, naming, verbal fluency, and verbal and visual reasoning.

Comparison with prior results obtained on 12/03/2019 revealed the following pattern of interim changes:

Declines were found in the areas of:

- Intellectual functioning (Full Scale Index: average to low average)
- Semantic fluency (low average to deficient)
- Inhibition (borderline impaired to deficient)
- Graphomotor sequencing (further in deficient range)

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- Basic attention (forward and backward: average to low average; sequencing: average to borderline impaired)
- Learning of prose material (average to borderline impaired)
- Delayed recall of prose material (low average to borderline impaired)
- Visuospatial construction (Clock drawing and Rey-O)

No interim Improvements were found as compared to his performance on 12/03/2019.

Mr. Brockman's current cognitive functioning was impaired across all domains assessed, with significant interim declines noted from his evaluation in March 2019. He continued to demonstrate significant cognitive fluctuations throughout the evaluation with confusion and impaired abilities to follow instructions. Mr. Brockman's pattern of neuropsychological performance continues to indicate a dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. Mr. Brockman denies experiencing well-formed visual hallucinations; however, he has experienced visual illusions, brief visual hallucinations, and a recent delusional episode. His current cognitive pattern and his parkinsonism, taken together with his dementia at the time of diagnosis of his movement disorder, cognitive fluctuations, and REM Behavior Disorder continue to suggest Dementia with Lewy Bodies. His cognitive profile demonstrated interim cognitive declines across all domains assessed.

Based on the current cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it remains my opinion that Mr. Brockman is unable to participate and aid in his own defense. Due to the neurodegenerative nature of this disease and the lack of effective treatments, his prognosis is for continued cognitive decline. He is unable to recall and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that will allow him to make comparisons and weigh his options.

It is this examiner's opinion based on record review, behavioral observations, patient interview, and current and previous neuropsychological assessments.



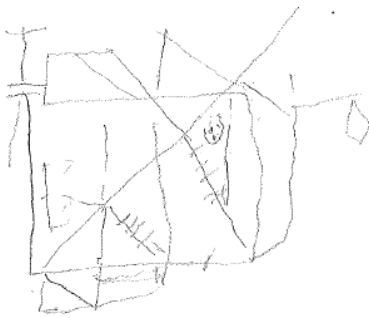
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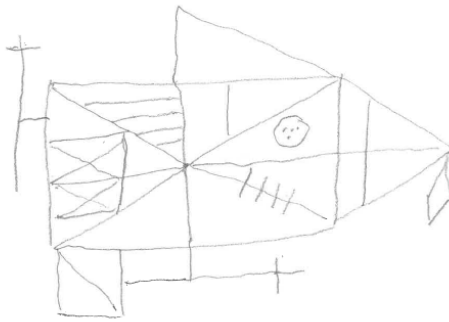
EXHIBIT S

Examples of visuospatial performances for Mr. Brockman

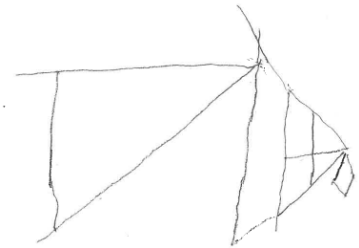
Rey Complex Figure Test – Copy of a Design



03/01/2019

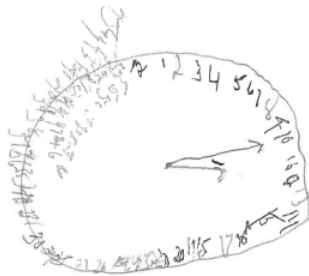


12/03/2019

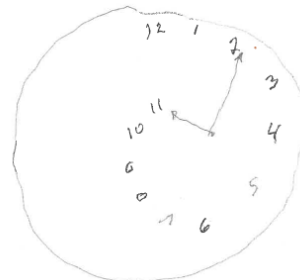


10/07/2020

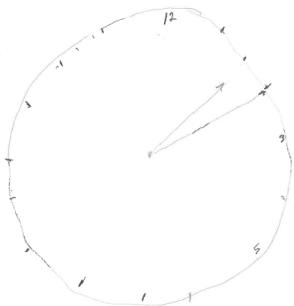
Clock Drawing "10 after 11"



03/01/2019



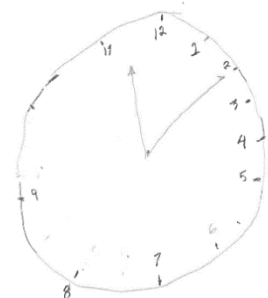
12/03/2019



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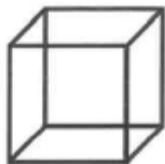


10/07/2020



10/07/2020

Copy



Copy of a cube 10/07/2020

1st Attempt



Copy of a cube 10/07/2020

2nd Attempt